

EXHIBIT 18

Lawson Bernstein, MD, PC

P.O. Box 81977

Pittsburgh, PA 15217

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12/7/12

My name is Lawson Bernstein, MD. I have practiced clinical and forensic psychiatry since 1991 and 1994 respectively. I was Director of psychiatric residency training at the University of Pittsburgh School of Medicine/Department of Psychiatry from 1991-1994. I worked as a clinical psychiatrist on Pennsylvania's Capital Offender Unit/"Death Row" from 1992 -1994. I held various academic titles at the University of Pittsburgh School of Medicine from 1991 – 2008, first as full time faculty and after 1994 as volunteer teaching faculty. I am currently a lecturer at Duquesne Law School and the Cyril Wecht Institute of Forensic Science and the Law on topics related to Forensic Psychiatry and Neuroscience. I have acted as a forensic consultant to multiple local, state and federal agencies since 1994. I have evaluated hundreds of individuals, both clinically and forensically, with histories similar to Mr. David Smith. My CV, forensic fee schedule and Rule 26 testimony disclosure are attached to this report. I have reviewed the records you forwarded which are also listed as an attachment to this report.

Briefly, this was a then 28 year-old man with a psychiatric history of Schizoaffective Disorder, Substance Abuse, Antisocial personality disorder and longstanding treatment non-compliance. Mr. Smith was a regular abuser of over-the-counter cough medicine containing Dextromethorphan, a substance with known "PCP"/Phencyclidine-like intoxicant and psychotomimetic properties. Mr. Smith's regular abuse of a psychotomimetic agent like Dextromethorphan more likely than not made his underlying psychotic disorder worse and more difficult to treat. Further, Dextromethorphan intoxication and other forms of

substance abuse and dependence were a regular feature of Mr. Smith's day-to-day. This fact coupled with his Schizoaffective disorder, resulted in a chronically chaotic and progressively marginalized existence and exceedingly poor clinical prognosis.

As the results of his Schizoaffective Disorder, Antisocial Personality Disorder, Substance Abuse and treatment non-compliance Mr. Smith was frequently homeless and/or intoxicated. Mr. Smith had regular contact with police due to public intoxication and symptoms from his untreated psychiatric and substance abuse problems. Mr. Smith had been psychiatrically hospitalized multiple times and was a frequent patient at local emergency rooms. The week prior to 9/9/10 Mr. Smith had been emergently treated for Dextromethorphan intoxication. On the night before 9/9/10 he had been emergently treated for intoxication.

On 9/9/10 Mr. Smith engaged in an extended altercation with police and then lost consciousness. At the time of subsequent emergent hospitalization he had a documented blood Dextromethorphan level of 2000ng/l (therapeutic 0.5 – 5.9ng/ml) due to acute OTC cough medicine abuse. Concurrent drug screen for one of his psychiatric drugs (lamotrigine) produced a negative result. He subsequently died from cerebral anoxia and it's sequelae on 9/17/10.

You have posed a number of questions to me regarding the decedent.

1. What was the expected life span of Mr. Smith?

Mr. Smith suffered from a number of longstanding psychiatric diseases plus severe substance abuse. A recent study published by the Ontario Ministry of Health¹ examined the burden of mental illness compared to cancer and infectious disease in regards to excess mortality and lost productive years. This study estimated the adverse effect of mental illness plus substance abuse as 1.5 times that of cancer and 7 times that of infectious disease. This study replicates

¹ Opening Eyes, Openings Minds – The Ontario Burden of mental illness and addictions report, Ratnasingham S, Cairney J, Rehm J, Manson H, Kurdyak PA. October 2012

others in the literature which have concluded that chronic mental illness plus substance abuse predicts substantial excess mortality in the sufferers.

Mr. Smith had a history of regularly engaging in dangerous behaviors or exposing himself to dangerous situations. These include passing out on railroad tracks while intoxicated, experiencing incapacitating intoxication/"overdosing" requiring medical treatment (including the week and the night before the 9/9/10 event), contracting sexually transmitted diseases (and thereby placing himself at risk for Hepatitis B and/or HIV), episodic homelessness (exposing him to the dangers of street life) and committing petty crimes. I believe that Mr. Smith's mix of severe mental disorder(s), regular substance abuse, medical history (including treatment for sexually transmitted diseases), legal history, frequent homelessness and treatment non-compliance predicted at best a life expectancy of 50 years.

2. What factors were extant on the date of the altercation that predicted Mr. Smith's level of violence?

At the time of the altercation Mr. Smith was apparently non-compliant with psychotropic medication (as was his habit), severely intoxicated on Dextromethorphan and other constituents of cough syrup, and more likely than not acutely psychotic from both of these factors both singly and in the aggregate. In particular the combination of high dose Dextromethorphan (which as noted above is an intoxicant with PCP-like properties) plus un-medicated psychosis is a potent recipe for bizarre violent acting out behaviors such as those evinced by Mr. Smith. It is also important to note that individuals intoxicated with Mr. Smith's blood level of Dextromethorphan but *without* an underlying autonomous psychotic disorder can present identically to his presentation at the YMCA on 9/9/10.

3. What was Mr. Smith's strength potential given the factors in item #2?

Predicated on the factors extant in item #2, Mr. Smith's capacity for extended periods of high physical exertion related violence would have been substantial. In fact, the type of prolonged struggle captured by an officer's pen-camera is emblematic of an excited

delirium-like state in individuals with Mr. Smith's acute and chronic psychiatric history and/or Dextromethorphan intoxication.

4. What was Mr. Smith's employability and prospect for further educational achievement?

Mr. Smith was chronically mentally ill with a psychotic disorder, a long-term substance abuser whose apparent drug of choice predictably worsened underlying psychosis, was frequently treatment non-compliant and effectively homeless. This had been his condition for quite some time per record review. As such, his prospects for gainful employment and/or educational achievement were negligible.

5. What was Mr. Smith's emotional capacity to provide a stable, loving and supportive influence to other family members.

Referencing the above, individuals such as Mr. Smith lead chaotic and frequently dangerous lives in which their capacity for daily subsistence (let alone supportive family interactions or a productive life) is severely impaired. The records do not reflect an individual with a strong family life, and indeed his capacity for this would have been minimal for obvious reasons. In addition, psychotic spectrum disorders such as Schizoaffective Disorder produce delusions and/or hallucinations that interfere with the formation and maintenance of close interpersonal relationships. In individuals such as Mr. Smith, a comorbid substance abuse disorder (particularly with a psychotomimetic agent like Dextromethorphan) routinely makes these psychotic symptoms worse. Substance abuse also exerts its own deleterious effects on the capacity to form stable and loving relationships. Even in non-psychotic individuals chronic or intermittent intoxication, possible physical dependence, disinhibited mood state due to abuse and/or withdrawal, prevarication and other associated phenomena related to addiction are all inimical to the development and maintenance of close interpersonal relations and/or an intact family life.

Given the diagnoses extant in Mr. Smith and treatment non-compliance it is highly unlikely that his family would have been ignorant of his psychosis and associated aberrant behaviors and their adverse effect on interpersonal relationships. Schizoaffective disorder

is chronic and even when treated does not fully remit. Thus his psychotic symptoms would have been extant, albeit in a muted state, even with pharmacological treatment and extended sobriety.

Plaintiff's psychiatric expert has opined that with different treatment(s) Mr. Smith's conditions might have improved as pertains to family life, work and/or educational achievements. Given the facts of this case, the presence of both a serious chronic psychotic disorder and severe substance abuse with a psychotomimetic agent, the likelihood of future treatment compliance and associated symptom remission allowing these potential positive outcomes was low.

In summary, on 9/9/10 Mr. Smith presented as acutely psychotic and violent more likely than not due to an unmedicated psychotic disorder coupled with acute severe dextromethorphan intoxication. Both these factors, particularly together, are associated with a propensity for extended periods of bizarre violent behavior. Mr. Smith's capacity for gainful employment, educational success and/or a stable loving family life was minimal given the fact pattern of this case. His clinical prognosis was poor and it was unlikely he would have achieved a life span anywhere near his actuarial one for the multitude of reasons noted above.

I reserve the right to amend, expand or change my opinions based on new information disclosed to me. All opinions are expressed within a reasonable degree of medical certainty.

Sincerely,


Lawson Bernstein, MD

David C Smith – records reviewed

United States District Court – District of Minnesota

Larry E Smith, as trustee for the Heirs and Next of Kin of David Cornelius Smith vs. Timothy Gotman and Timothy Callahan, acting in their individual capacities as Minneapolis police officers, and the City of Minneapolis

Plaintiff's Second Supplemental Answers to Defendants' Interrogatories

First Amended Complaint

Answer of Defendants Gorman, Callahan and the City of Minneapolis to Plaintiff's First Amended Complaint

Plaintiff's Responses to Defendants' Request for Production of Documents

Plaintiff's Answers to Defendants' Interrogatories

Plaintiff's First Supplemental Answers to Defendants' Interrogatories

Plaintiff's Responses to Defendants' Request for Production of Documents (Second Set)

Plaintiff's Second Supplemental Answers to Defendants' Interrogatories

Videotaped deposition transcript of Timothy Callahan – 01/30/2012

Videotaped deposition transcript of Timothy Gorman – 01/30/2012

Videotaped deposition transcript of Andrew M Baker, MD – 01/25/2012

Videotaped deposition transcript of Andrew M Baker, MD – Volume II – 02/08/2012

Videotaped deposition transcript of Sigrid Finke – 07/11/2012

Deposition transcript of Natalie K Harris – 05/18/2012

Videotaped deposition transcript of Martin J Stachnik – 05/17/2012

Videotaped deposition transcript of William Christopher Taylor – 07/26/2012

Videotaped deposition transcript of Courtney Troyer – 05/18/2012

Videotaped deposition transcript of Angela Weber – 07/26/2012

Videotaped deposition transcript of Jo Ann Zillhardt – 07/11/2012

Expert Report of John J Ryan

Correspondence between David Smith & Angela Smith

Myspace posts of "King David"

Hennepin County Medical Examiner reports

American Indian Community Development Corporation

Cedar Ridge Treatment Center

Fairview University Riverside Campus

Hennepin County Mental Health Center

Karol Neuropsychological Services & Consulting

MN Department of Human Services

Park Nicollet Methodist Hospital

Vinland Center

State of Minnesota Office of the Ombudsman for Mental Health and Developmental Disabilities

Oak Grove Residential Treatment Center

Hennepin County Medical Center

Hennepin County Human Services & Public Health Department

Mosaic Apartment Services, Inc

REM Hennepin – Brooklyn Center

Mill City Clinic

Report of Michael M Baden, MD – 02/28/2012

Report from The Tox Group – 11/13/2012

Expert Report of Dr. S Charles Schulz, II

Report titled: *Opening Eyes, Opening Minds: The Ontario Burden of Mental Illness and Addictions Report*

LAWSON F. BERNSTEIN, MD, PC
CASE LISTING - JANUARY 2007 - NOVEMBER 2012

Case Name	Law Firm	Time Period	Testimony or Deposition	w/c	PI
Keiderling, Eric	Lenanhan & Dempsey	Jan-07	Testimony		
Berning, Lille		Jan-07	Deposition		
Smith, Robert v Young Touchtone	Malone, Middleman	Feb-07	Testimony	w/c	defense
McDowell, Mark	Pietragallo, Bosick & Gordon	Feb-07	Deposition	w/c	defense
Felix, Armen	Cheehardy, Sherman, Ellis, Murray	Feb-07	Testimony	criminal	defense
Cooke, James, State v	Robb, Leonard & Mulvihill	Feb-07	Deposition	w/c	plaintiff
Rios, Miguel	Delaware Public Defender's Office	Feb-07	Testimony	w/c	defense
Fennell, Scott	Federal Defender's Assoc	Feb-07	Deposition	w/c	plaintiff
Bayssinger, William	Painter, Donald v New Image Press	Mar-07	Deposition	w/c	defense
Brooks, Dustin	Curran, Saundra v National City Corporation	Mar-07	Deposition	w/c	defense
Brooks, Dustin	Innocenti, Kendra vs. Cook's Pharmacy	Mar-07	Deposition	w/c	defense
Fundis, Tammy	Dickie, McCamey & Chilcote	Apr-07	Deposition	w/c	defense
Wright v Wright	Lenanhan & Dempsey	Apr-07	Deposition	w/c	defense
State of Ohio v Janae C Ray	Dapper, Baldassare, Benson, Behlir	Apr-07	Deposition	w/c	defense
Leuschen, Robert	Wilder & Mahood	May-07	Deposition	w/c	plaintiff
Davis, Richard	Stephanie Greenberg	May-07	Testimony	w/c	defense
Greece, Mark	Burns, White & Hickton	May-07	Deposition	w/c	defense
Cummings, Keith v Horsehead Corp.	Mammen, Moduszewski, Bordonaro	Jun-07	Deposition	w/c	defense
Wilson, James	Dickie, McCamey & Chilcote	Jun-07	Deposition	w/c	defense
Watson, Kim M	PA Dept of State, Board of Nursing	Jun-07	Testimony	criminal	prosecuting
Pritchett, Leonard	Pietragallo, Bosick & Gordon	Jul-07	Deposition	w/c	defense
McNeill, Daniel and Dawn McNeill v. US Airways, Inc., Philip C Pietragallo Bosick & Gordon	Knox, McLaughlin Gornall & Stenn	Jul-07	Deposition	w/c	defense
Doe, Jane v David Gillispie, as agent of Kanawha Co Board c Bailey & Wyant	PA Dept of State, Board of Nursing	Jul-07	Testimony	criminal	prosecuting
Rebecca B Caldwell, as Personal Representative of the Estate of Bailey & Wyant	Timothy Dawson	Aug-07	Deposition	w/c	defense
Algeo, William	Dickie, McCamey & Chilcote	Aug-07	Testimony	PI	defense
Caldwell, Doug v Senex Explosives, Inc	Eisenberg & Torisky	Aug-07	Disc Depo	PI	defense
Baumann, Tyler, State of WV v	Wilson, Frame, Benninger & Methe	Aug-07	Disc Depo	PI	defense
Bielic, Cheryl	PA Dept of State, Board of Nursing	Oct-07	Deposition	medmal	defense
Davis, Gregory v Nelson Tree Service	Pietragallo Bosick & Gordon	Oct-07	Deposition	w/c	defense
Flaherty, Lynn A & James Flaherty v St Clair Memorial Hospit	DelSole Cavanaugh	Oct-07	Deposition	w/c	defense
McGough, Mark v Aspen Valley Contracting	Robb, Leonard & Mulvihill	Oct-07	Testimony	criminal	defense
Strothmore, Estate of Timothy v United Summit Center	Steptoe & Johnson	Oct-07	Testimony	criminal	prosecuting
Strothmore Estate of Timothy v United Summit Center	Steptoe & Johnson	Nov-07	Deposition	w/c	defense
Carnes, Robert v Christopher L Stewart; Edwin R Roup, Jr; ar Dapper, Baldassare, Benson, Behlir		Nov-07	Testimony	medmal	plaintiff
Cawthorn, Joyce	Abes, Baumann	Dec-07	Deposition	w/c	defense
Smith v Akhtar	Williams, Hall & Latherow	Dec-07	Testimony	medmal	plaintiff

LAWSON F. BERNSTEIN, MD, PC
CASE LISTING - JANUARY 2007 - NOVEMBER 2012

Case Name	Law Firm	Time Period	Testimony or Deposition
Strother, Estate of Timothy v United Summit Center	Stephens & Johnson	Dec-07	Testimony
Trevena, Edwin vs. Primehealth, et al.	Paul M. Kaufman	Jan-08	Testimony
Andreen, Kelly	Evaluation Specialists		
Callender, Gail v Allegheny Ludlum Corporation	Dapper, Baldassare, Benson, Behlir	Jan-08	Deposition
Lundquist, Nicholas	Littler Mendelson	Jan-08	Deposition
Buynevsky, Paul v Jacob A Vachal	Feb-08	Deposition	w/c defense
Rasey, John K Jr and Diane Rasey vs Transflo Corporation, Yates, McLamb & Weyher	Mar-08	Deposition	w/c defense
Corey, Robert Jennings, John	Mar-08	Disc Depo	w/c defense
Pulford, Daniel	Mar-08	Deposition	w/c defense
Clark, Richard	Mar-08	Deposition	w/c defense
Dayton, Margaret v Gayle R. Yunk Martello-Adams, Terry	May-08	Deposition	w/c defense
Brannaka, Pamela v Family Festivals Assoc, Inc	May-08	Deposition	w/c defense
Russell, Renee v UPMC Presbyterian Shadyside Estef, et al. v John Bushovisky, d/b/a Traveler's Paradise, et al	May-08	Deposition	w/c defense
Hager, Christine	Jun-08	Deposition	w/c defense
Brown, Marlin	Jun-08	Deposition	w/c defense
Laurianno v Arbour-Fuller Hospital, et al. Carvall, Amanda	Jul-08	Deposition	w/c plaintiff defense
Quinn, Mary Lee v Presbyterian Senior Care Perrone, Amy v Highmark	Jul-08	Deposition	w/c defense
McCullough, et al., v Veterans Memorial Amvets Post 0821, et al. Cheza, Paul v Chadderton Trucking	Aug-08	Deposition	w/c defense
Lufkins, Michelle	Aug-08	Deposition	w/c defense
Alexander, Deanna v Penn State University, et al. Ferranti, Joseph v Liggett Group	Oct-08	Deposition	w/c defense
Moore, Kimberly	Nov-08	Deposition	w/c defense
Cox, Michael, State of West Virginia v Adams, Robert, Commonwealth v Landrum, Randy	Nov-08	Deposition	w/c defense
Gibson, Ronald, Commonwealth v Lufkins, Michelle	Jan-09	Deposition	w/c defense
Banks, Peggy Sue	Jan-09	Deposition	w/c defense
Sexton, Catherine v Virginia Phillips Cozza, Theodore	Feb-09	Disc Depo	w/c defense
Johnston, David R v Plum Contracting, Inc	Feb-09	Testimony	w/c criminal
Salopek, Linda & David Gianessi v Eat'n Park Hospitality Gro Dickie, McCamey & Chilcott	Mar-09	Testimony	prosecuting
Kisak, Dennis v U.S. Steel	May-09	Testimony	criminal
McGee, Beth	May-09	Testimony	prosecuting
	Jun-09	Deposition	w/c criminal
	Jul-09	Deposition	w/c defense
	Aug-09	Deposition	w/c defense
	Oct-09	Deposition	w/c defense
	Oct-09	Deposition	w/c defense
	Dec-09	Deposition	w/c defense

LAWSON F. BERNSTEIN, MD, PC
CASE LISTING - JANUARY 2007 - NOVEMBER 2012

Case Name	Law Firm	Time Period	Testimony or Deposition	
Cole, Anne, Thomas J Duggan, Joseph T Duggan, Jr, Barbara Hartline, Dacus, Barger, Dreyer & I Hampton, Stacie, et al. v. Russell & Illinois Armored Car, et al Norris, Choplkin & Schroeder, LLP Sawitz v Sawitz	PA Dept of State, Board of Medicin Eisenberg & Torsky	Dec-09 Dec-09 Dec-09	Disc Depo Disc Depo Deposition	PI PI PI
Maro, Cynthia Ames, Lawrence Sempkowski, Curtis McGinn, Patricia, Personal Representative the Estate of Mich. Jeffrey P Paul	Cipriani & Werner	Jan-10 Jan-10 Jan-10	Testimony Deposition Deposition	criminal prosecution w/c w/c
Jentony, Henry, et al. v Lee J Colegrove, et al. Hall, Arthur v RJ Reynolds, et al Townsend, Estate of Frank v RJ Reynolds, et al.	Sutter, O'Connell & Farchione	Jan-10 Jan-10 Jan-10	Disc Depo Disc Depo Disc Depo	PI PI PI
Stanley, Andrew v Aline Gilbert Johnson, MD, et al. Laurianno, Joanne Admx., et al. v. Arbour-Fuller Hospital, et al. Green, Eva Dunlap v Housing Authority of the City of Charlotte Kennedy, Kennedy & Kei	Lopez, Kimberly v Metropolitan Government of Nashville and Blackburn & McCune, PLLC	Jan-10 Feb-10 Feb-10	Disc Depo Disc Depo Disc Depo	PI PI PI
Trieschok, Timothy Hall, Arthur v RJ Reynolds, et al. Collins, Cynthia vs Cara L Zieler & State Farm Mutual Automc Robb Leonard Multihill	Moyles Law Firm	Feb-10 Mar-10	Testimony Deposition	med mal PI
Townsend, Estate of Frank v RJ Reynolds, et al. McClelland, William	Womble, Carlyle	Mar-10	Testimony	plaintiff
Juliano, Dominica, a minor, by & thru her parent & natural gue MacDonal, Iliig, Jones & Britton Ritchey, Dennis L v Wal-Mart	Womble, Carlyle del Sole, Cavanaugh	Mar-10 Apr-10	Testimony Deposition	defense plaintiff
Conrad, Eric v Veeder Root/Danaher Corp Demchak, George	Post & Schell	Apr-10	Testimony	PI
Urban, Eric	Cipriani & Werner	May-10	Deposition	defense
Young, Kimberly	Ogg Cordes Murphy & Ignelzi Stofo Law Offices	May-10	Deposition	plaintiff
Rea, Mary	Charwell Law Offices Frankovitch Antakakis Colantino Sim Pietragallo Gordon Alfano Bosick &	May-10	Deposition	plaintiff
Buczek, James	Talenfeld Mitchell David Personal Representative of the Estate of Womble, Carlyle	Jun-10	Disc Depo	defense
Massie, Debra v Dr. Anthony T Dinh, et al. Riemann, Duane E	Curry & Tolliver, PLLC	Jun-10	Deposition	PI
Allen, Patricia L and Andy R Allen, Sr, her husband. Francois Womble, Carlyle Czaikowski, Frank v YMCA	Early Ludwick Sweeney & Strauss Koskoff, Koskoff & Bieder	Jun-10 Jul-10	Disc Depo Disc Depo	defense defense
Wingrove, Gregory S Rezak, Joseph	Abes, Baumann Dapper, Baldassare, Benson, Behlir Malone, Middleman	Aug-10 Sep-10	Disc Depo Deposition	plaintiff plaintiff
Robinson, Joanna	Department of State	Sep-10	Deposition	defense
Nida, David	Woomer & Hall	Oct-10	Testimony	prosecuting
Rose, Stevenson, Commonwealth v. Kowalyk, Vanessa	Ditenderfer, Rothman & Haber	Dec-10	Deposition	criminal defense
Igoe, Tracie	Dickie, McCamey & Chilcote	Dec-10	Deposition	w/c defense

LAWSON F. BERNSTEIN, MD, PC
CASE LISTING - JANUARY 2007 - NOVEMBER 2012

Case Name	Law Firm	Time Period	Testimony or Deposition
Katz, David v. Liggett Group, LLC, et al.	Kasowitz, Benson, Torres & Friedman	Jan-11	Disc Depo
Comly, Danielle	Pietragallo Gordon Alfano Bosick & Weinheimer, Schadel & Haber	Jan-11	Deposition
Roy-Vesley, Cali v Richard Edwards	Tucker Arensberg	Feb-11	Deposition
Jurcevich, Donna	Kasowitz, Benson, Torres & Friedman	Feb-11	Deposition
Blitch, Josephine	Department of State	Feb-11	Deposition
Ohis, Christine	Ogg, Murphy & Perkosky	Feb-11	Testimony
Palmer v Nassan	Steffish & Lafferty, PC	Feb-11	Testimony
Roxberry, Melissa vs. Voices for Independence	Womble, Carlyle	Mar-11	Deposition
Oliva, Allen C v RJ Reynolds, et al.	Womble, Carlyle	Mar-11	Testimony
Allen, Patricia L and Andy R Allen, Sr, her husband, Francois Womble, Carlyle	Dell, Moser, Lane & Loughney, LLC	Apr-11	Disc Depo
Allen, Patricia L and Andy R Allen, Sr, her husband, Francois Womble, Carlyle	Sutter, O'Connell & Farchione	May-11	Testimony
Miller, Allison v Johnstown Housing Authority	Buchanan Ingersoll Rooney	Jun-11	Deposition
Kenny, Carol v UPMC Passavant Cranberry	Timothy C Andrews, Esquire	Jul-11	Deposition
Jointon, Henry, et al. v Lee J Colegrove, et al.	Carpenter, McCadden & Lane	Jul-11	Testimony
Richter, Theresa R, Personal Representative of the Estate of Womble, Carlyle, Sandridge & Ri	Gover, Perry & Shore	Aug-11	Deposition
McAuliffe, Richard Commonwealth vs. Irdi, Nigel	Yates, McLamb & Weyher	Aug-11	Testimony
Erman, David F & Jane F Erman v RJ Reynolds Tobacco Cr Womble Carlyle	Pollock Begg Komar Glasser LLC	Aug-11	Deposition
Nzambi, Emmanuel	Yates, McLamb & Edelstein	Sep-11	Disc Depo
Ojeda, Retnado as Personal Representative for the Estate of Womble, Carlyle, Sandridge & Ri	Yates, McLamb & Weyher	Sep-11	Testimony
McKeel, David v Joseph Rezk t/a Punxsutawney Medical Sup	Pollock Begg Komar Glasser LLC	Sep-11	Testimony
Cileo, Rita	Yates, McLamb & Weyher	Sep-11	Deposition
Pollock, Phyllis L v Hugh P Pollock	Yates, McLamb & Weyher	Sep-11	Disc Depo
Todd, Nancy	Yates, McLamb & Weyher	Oct-11	Testimony
United States v Justin Smith and Brandon Piper	Yates, McLamb & Weyher	Nov-11	Disc Depo
Czajkowski, Frank v YMCA	Yates, McLamb & Weyher	Nov-11	Testimony
Cileo, Rita	Yates, McLamb & Weyher	Dec-11	Testimony
	Yates, McLamb & Weyher	Jan-12	Deposition

Lawson F. Bernstein, M.D., P.C.
P O Box 81977
Pittsburgh, Pennsylvania 15217

Administrative Assistant Mary Quinlisk 412 600-7996
Office Fax 412 422-5203

Fee Schedule, Notification and Cancellation Policy

Case Name: LFB #

Revised 2/2012 PLEASE READ THIS CAREFULLY:

1. Hourly rate for file review, trial preparation, other: \$500/hr (\$550/hr for < 96 hr/4 business days turn around)
2. Standard IME report fee: minimum \$3000, general range \$3000-\$5000 depending on the records to review, fee greater for voluminous records.
3. Deposition/testimony :
 - A. Flat fee for workers' compensation deposition = \$1900
 - B. Flat fee for all other depositions < 4 hours = \$3000, then \$500/h thereafter including any travel time.
 - C. Flat fee for local live court testimony (less than 90 highway miles Pittsburgh), one calendar day or part thereof = \$6000 / day.
 - D. Flat fee for out-of-town live testimony (greater than 90 highway miles from Pittsburgh or requiring air-travel), one calendar day or part thereof = \$8500 / day.
 - E. Minimum video deposition fee = \$4500
 - F. Deposition/testimony prepayment due no less than 2 weeks prior to date of appearance.
4. Proposed dates for IMEs and/or depositions requested by you and subsequently provided by my office will be held unconfirmed for no more than 2 weeks from the calendar date they are provided to you.
5. Formal written notice for trial and/or deposition dates must be given no less than 4 calendar weeks in advance of proposed appearance, or my appearance cannot necessarily be guaranteed.

6. Trial and deposition prep fees are billed separately from appearance fee. Testimony prep begins at least 4 weeks pre-appearance. These fees are non-refundable.
7. Prepayment & Cancelled Deposition fees - Prepayment by certified check no later than 2 weeks prior to deposition. Cancellation less than 7 calendar days notice = \$2000, less than 96 hr notice (4 calendar days) = fee in full. Notice is determined from 8am on original date of scheduled testimony.
8. Cancelled workers' compensation deposition (notice is determined from @ 8am on date of exam) < 4 calendar days notice = \$1000
9. Prepayment & Cancelled Court testimony - Prepayment by certified check no later than 2 weeks prior to deposition, cancellation less than 7 calendar days notice = \$3500 (out of town = \$5000), < 96 hr notice (4 calendar days) = fee in full. (Notice is determined from 8 am on original 1st day of trial);
10. Cancelled IME (notice is determined from @ 8am on date of exam) < 5 calendar days notice = \$1500; < 24 hr/ one calendar day notice = \$3000: No-show for IME = \$3000
11. MMPI-2 personality/malingering psych testing & report = \$500
12. All travel expenses (car rental or mileage, air travel, hotel, etc) are to be paid at least 2 weeks in advance by the client.
13. Retainer of \$3000.00 due at onset of this matter, prior to beginning of any work.
14. A formal written notice at least 8 weeks prior to any proposed trial or deposition date is required or an appearance date cannot be guaranteed.
15. Failure to adhere to any aspect of items #1-11 will result in my immediate withdrawal from the case. ALL FEES PAYABLE IN ADVANCE Bills unpaid > 60 days from date posted may incur additional penalties or may be submitted for collection. Please read, sign and fax back.
16. ELECTRONIC DOCUMENT TRANSFER - No more than 100 pages of documents per forensic case can be sent to this office via electronic document transfer. All other case records must be sent as printed documents to my office. By request, this office will prepare an estimate for document printing. This estimate must be prepaid prior to document printing. Document printing costs are not covered by the initial case retainer.

ADDITIONAL SIGNATURE PAGE→

"I understand this fee schedule is a written contract between myself and/or the organization I represent and Lawson F. Bernstein, MD, PC. I have reviewed this fee schedule in its' entirety. My signature denotes formal receipt and acceptance of this fee schedule".

Signature:

Date:

- PLEASE REFER TO INVOICE/ESTIMATE NUMBER IN ALL BILLING CORRESPONDENCE
- CASE ESTIMATE PROVIDED ON REQUEST.

LAWSON F. BERNSTEIN, JR., M.D.

Correspondence Address:
Post Office Box #81977
Pittsburgh, Pennsylvania 15217

Office Telephone Number: 412-422-9240
Administrative Assistant, Mary Quinlisk - 412-600-7996
Fax Number: 412-422-5203
Federal Tax ID: # 25-176-2150 (*Lawson F. Bernstein, M.D., P.C.*)
Website: www.lfbmdpc.com
Email: lawsonbernstein@hotmail.com

PROFESSIONAL EXPERIENCE

1994-Present Lawson F. Bernstein M.D., P.C.

Forensic & Neuropsychiatric consulting practice with expertise in the assessment and treatment of Brain Injury, Seizure disorders, stroke, toxic environmental exposure, chronic pain conditions, addiction and other neurological/neuropsychiatric conditions.

2005-Present Consultant, Department of State, PA Bureau of Professional and Occupational Affairs

Case reviewer & consultant for above office as pertains to neuropsychiatrically impaired PA. Professionals (physicians, nurses, pharmacists, etc.)

1996-Present Physician Volunteer, Allegheny County Shelter for the Homeless

1994-Present Forensic Psychiatric Consultant, Office of the Public Defender of Allegheny County, Court of Common Pleas -Juvenile Division & Family Division, Orphan's Court - Allegheny County, Attorneys general Offices of PA, OH & VW, various other State & Federal Agencies.

Forensic Psychiatric Evaluation of Criminal Defendants, Juveniles, Parents and Adoptees, and testimony in various litigation proceedings.

1997-2010 St. Margarets Memorial Hospital, UPMC, Pittsburgh, Pa.

Psychiatric Consultant to medically complicated patients, including Critical Care Units.

2004-2009 **Neurotoxicology & Neuropsychiatry Consultant to Allegheny County Office of the Coroner.**
Forensic case reviewer for above office as pertains to neurotoxicological issues and the manner of death of a decedent under investigation by the Coroner.

1991-2009 **Harmarville Rehabilitation Center, Brain Injury Unit, Pittsburgh, PA, Staff Psychiatrist**
Consulting neuropsychiatrist to brain injury, stroke & chronic pain programs.

2000-2002 **Advisor; State Senate Subcommittee on Youth & Aging – Initiative on Violence & Mental Illness, Harrisburg, PA**
Invited to present proposal to reform Mental Health Act and Uniform Firearms act in wake of two shooting rampages in Pittsburgh.

1998-2005 **Consulting & Teaching Staff, Greater Pittsburgh Rehabilitation Hospital**
Consulting neuropsychiatrist to brain injury & stroke programs.

1998-1999 **Consulting Staff, UPMC/Passavant Hospital**
Psychiatric Consultant to medically complicated patients, including Critical Care Units.

1993 -1995 **Member; Governor's Task Force for State Mental Health Planning Council, Harrisburg, PA**
Non-Voting member of committee delegated to assign 80 million dollars in community block grants for mental health services

1992-1995 **Western Psychiatric Institute and Clinic, Director, General Psychiatry Training Program; Co-Director, Office of Residency Training**
Responsible for monitoring education of 65 residents/fellows, and academic teaching activities of 255 faculty, overseeing office staff of 6, monitoring budget of 2.8 million dollars, setting educational goals and initiatives for one of largest training programs in the U.S.. Position involved major presentations, recruitment activities and liaison with other medical specialty leadership at university, and senior administration at WPIC.

1992-1994 **Chairperson, AADPRT Committee on Managed care and Residency Education**
National Committee to evolve strategy to modify training and advocate for continued government funding of psychiatric residency education. Involved liaison with other American Psychiatric Association Committee chairpersons and various managed care executives.

1992-1994 **UPMC Brain Injury Program, Attending Psychiatrist**

1992-1993 **Allegheny County Jail, Allegheny County MH/MR, Pittsburgh, PA, Psychiatric Consultant**
Performed psychiatric service assessment utilized by jail administration to obtain psychiatric nurse clinician from current health care vendor at this institution

1991-1993 **State Correctional Institute at Pittsburgh (SCIP) Department of Corrections, Pittsburgh, PA, Psychiatric Consultant**
Responsible for creating "team" concept of care delivery to inmates, utilizing multidisciplinary approach. Developed psychiatric formulary of drugs to decrease utilization and set practice guidelines.

1991-1995 **University of Pittsburgh Medical Center, Psychiatric Consultation-Liaison Program/Service, Attending Psychiatrist – Trauma & Toxicology Programs**

1989-1991 **New York Hospital Burn Center, New York, NY, Research Associate**

1983-1987 **Marketing Representative, Continental Wingate Capital Corporation**

1978-1979 **Union Organizer, District 65, New York, NY**

1975-1978 **Principal, Lone Star Trucking and Freight Co.**

ACADEMIC APPOINTMENTS

2004 - 2009 **Clinical Instructor in Psychiatry, University of Pittsburgh School of Medicine**

2004 - 2008 **Assistant Professor of Psychiatry, Department of Family Practice, University of Pittsburgh School of Medicine**

1991-2004 **Assistant Professor of Psychiatry, University of Pittsburgh School of Medicine Western Psychiatric Institute and Clinic Pittsburgh, Pennsylvania**

EDUCATION AND TRAINING

UNDERGRADUATE:

1979 -	Hunter College, CUNY	BA 1983
1983	New York, NY	English/Classi cs Major

GRADUATE:

1983 -	Cornell University	MD 1987
1987	New York, NY	Medicine

POST GRADUATE:

1987 -	New York Hospital	Rotating
1988	New York, NY	Internship
1988 -	New York Hospital	Residency in
1991	Payne Whitney Clinic	Psychiatry
	New York, NY	

CERTIFICATION AND LICENSURE

SPECIALTY CERTIFICATION:

1992	American Board of Psychiatry & Neurology #36050
1996	American Board of Forensic Medicine #1164
1996	Diplomate, American Board of Forensic Examiners #3505

MEDICAL LICENSURE:

1988	New York State Board of Medicine #176951
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1991 Pennsylvania State Board of Medicine #MD-044058-L

MEMBERSHIPS IN PROFESSIONAL AND SCIENTIFIC SOCIETIES

1996- American Society of Addiction Medicine
1996- American College of Forensic Examiners
1995- American Medical Association & Allegheny County Medical Society
1992-1994 American Association of Directors of Psychiatric Residency Training
1991- American Academy of Psychosomatic Medicine
1986- American Psychiatric Association

HONORS and AWARDS

1983 Salk Award; Outstanding Undergraduate Research in the Biological Sciences
"Hyper Hydroxylation of Estradiols in Systemic Lupus Erythematosus"; Hunter
College, CUNY
1987 Diethelm Award; Outstanding Medical Student/Psychiatry; Cornell University
Medical College
1991 Llahmon Prize; Outstanding Psychiatric Resident Research; New York
Hospital/Payne Whitney Clinic
1991 Outstanding Psychiatric Resident Research, 2nd Prize; American Psychiatric
Association, Area 2 Council
1991 Granet Prize; Best Resident Consultation Psychiatry; New York Hospital/Payne
Whitney Clinic

PUBLICATIONS

REFEREED ARTICLE/CMES:

1. Bernstein, L., Jacobsberg, L., Ashman, T., Musagni, G., Goodwin, C., Perry, S.: Detection of alcoholism in burn patients. Hospital & Community Psychiatry 43(3):255-256; 1992.
2. Bernstein, L. & Daviss, S.: Organic anxiety disorder with symptoms of akathisia in a patient treated with the immunosuppressant FK506. General Hospital Psychiatry. 14:210-211; 1992.
3. Bernstein, L.: Trazodone treatment of targeted aggression in a mentally retarded man. The Journal of Neuropsychiatry and Clinical Neurosciences, 4(3):348; Summer 1992.
4. Bernstein, L.: Abrupt cessation of rapid-cycling bipolar disorder with the addition of low-dose L-Tetraiodothyronine (T4) to Lithium. Journal of Clinical Psychopharmacology. 12(6):443-444; December 1992
5. Bernstein, L. & Levin, R.: Catatonia responsive to intravenous Lorazepam in a patient with cyclosporine neurotoxicity and hypomagnesemia. Psychosomatics 34(1); Jan/Feb 1993.
6. Bernstein, L.: Pain Perception and Serum Beta Endorphin in Trauma. Psychosomatics 36 (3), May-June 1995

REVIEW ARTICLE/CMES & BOOK CHAPTERS

- A. Bernstein, L.: Mental Disorders, Tests & Drugs In Psychological and Scientific Evidence in Criminal Trials, 3d edition, JC Moriarity, Ed., West Group, St. Paul, MN-2000
- B. Bernstein, L.: Burn Trauma. In Principles of Medical Psychiatry, 3d edition, Stoudemire & Fogel Eds., Oxford University Press, New York, NY; 1999
- C. Bernstein, L.: Mentally disordered prisoners. Book review. J. Gunn, T. Maden, & M. Swinton, Eds., The Home Office. Journal Criminal Behavior & Mental Health; 1992.

D. Bernstein, L.: Residency Training and Health Care Reform. AADPRT Newsletter, Drell, Ed., School of Medicine, New Orleans, LA

E. Bernstein, L.: Burn Trauma In Acute Pain Management, 1998

F. Bernstein L.,: Textbook of Forensic Psychiatry Book Review, Gold & Simon Editors, American Journal of Psychiatry; 2011 *in press*

PEER REVIEWER, ACADEMIC JOURNALS

- American Journal of Psychiatry – 1994 to present
- Forensic Examiner – 1996 to present

CONFERENCE PROCEEDINGS

1. Co-author, Length of Antidepressant Therapy : Consensus Conference, University of Minnesota, 1995

PROFESSIONAL ACTIVITIES

Visiting Professorships

3/94	Visiting Professor, Cambria County Medical Society
6/94	Visiting Professor, Department of Psychiatry, Medical Center of Brazil at Sao Paolo

Individual Lectures/Presentations/Media Appearances

4/12	Mock Neuroscience Civil Trial 2 nd & 3 rd year law students Scientific Evidence Course, Duquesne University Law school, Pittsburgh, PA
3/12	“Neuroscience in Criminal & Civil Litigation” lecture to 2 nd & 3 rd year law students Legal Medicine Course, Duquesne University Law school, Pittsburgh, PA
9/11	Interview WPXI TV, Pittsburgh PA regarding mass shooting at UPMC Medical Center by Richard Shick.

3/12 "Diagnosis and Treatment of Depression in the injured worker" presented at Current Trends in Workers Compensation management Conference, Allegheny General Hospital, Pittsburgh, PA

3/12 "Neuroscience and the Law" lecture to 2nd & 3rd year law students Experts & Scientific Evidence Course , Duquesne University Law school, Pittsburgh, PA

2/12 "Neuroscience On Trial" presented at "Forensic Fridays" Conference, Wecht Institute of Forensic Sciences, Duquesne University, Pittsburgh, PA

10/11 "Towards a Neurobiology of Predation" presented at "Predators and their Prey" Conference, Wecht Institute of Forensic Sciences, Duquesne University, Pittsburgh, PA

9/11 "Psychiatric Disease in the Injured Worker", Pennsylvania Bar Institute, Harrisburg, PA.

9/11 Interview WPXI TV, Pittsburgh PA regarding appeal of Death Sentence in Richard Baumhammers case.

1/11 Interview WPXI TV, Pittsburgh PA regarding shooting of Rep. Giffords in Tucson, AZ

11/10 "PTSD", lecture given at first graduation ceremony for Allegheny County Veteran's Court

4/10 Interview WPXI TV, Pittsburgh PA regarding 11 year olds murder of stepmother, certification to try as an adult.

8/09 Interview WPXI TV, Pittsburgh PA regarding shooting at LA Fitness Center in Pittsburgh, PA.

5/09 Interview WTAE TV, Pittsburgh PA regarding shooting of 3 local police officers by Richard Poplowski

5/09 Interview WPXI TV, Pittsburgh PA regarding shooting of 3 police officers by Richard Poplowski

4/09 Interview TV-14, Pittsburgh PA regarding treatment of Depression

2/09 Interview WPXI TV, Pittsburgh PA regarding 11 year olds murder of stepmother

2/09 Interview KDKA TV and radio, Pittsburgh PA regarding 11 year olds murder of stepmother

1/09 Interviewed by Northwest Herald, McHenry County Illinois regarding "red flags" signs of violence in children

11/07 Psychiatric Disease in the Injured Worker – "mental/mental" claims, CLE lecture , Pittsburgh PA

11/07 Interviewed WGN radio, Chicago Ill. regarding baseball steroid abuse scandal

3/07 Interviewed by Geraldo Rivera/ NEWS regarding Virginia Tech mass murder case.

3/07 Interviewed by Kimberly Guilfoyle/ "Line Up" program FOX NEWS regarding multiple unsolved murder cases.

1/07 Interviewed by Kimberly Guilfoyle/ "Line Up" program FOX NEWS regarding Missouri Child Abduction cases.

1/07 Interviewed by Katrina Owens/ "Night Talk" PCNC regarding Missouri Child Abduction cases

10/06 Interviewed by ABC News/Good Morning America regarding Dissociative Amnesia

10/06 Interviewed by Pittsburgh Tribune Review regarding Amish Schoolhouse Murders.

10/06 Interviewed by Ann Devlin/ "Night Talk" PCNC regarding Amish Schoolhouse Murders.

8/06 "Evaluating Change in Mental Status, Practice & Pitfalls", CME/Grand rounds, UPMC St. Margaret's Hospital, Pittsburgh, PA.

1/06 "Psychiatric Assessment of the Potentially Abusive Parent", CME Seminar, Pittsburgh, PA.

10/05 "Management of drug/alcohol withdrawal in the acute med/surg patient", CME Seminar, Pittsburgh, PA.

9/05 "Work Related Psychiatric Injuries- Practices & Pitfalls", CME/CLE Seminar, Harrisburgh, PA.

8/05 "2nd generation antipsychotics, medical morbidity and mortality", CME/Grand rounds Harmarville Rehabilitation Center, Pittsburgh, PA.

3/05 "Work Related Psychiatric Injuries- Practices & Pitfalls", CME/CLE Seminar, Pittsburgh, PA.

3/05 "The BTK killer", Interview regarding serial killer arrest, CJOB radio station, Winnipeg Canada.

3/05 "The BTK killer", Interview regarding serial killer arrest, WPXI radio station/Night Talk Show, Pittsburgh, PA.

2/05 "School Noted Adoptees size", Interview regarding abuse of adopted children by adoptive parents, Tamp Tribune, Tampa, FL.

10/04 "Creutzfeld Jacob Disease", Interview regarding unusual epidemiological outbreak of this disorder in the local area, WAMC, Albany, N

8/04 "Little League can't escape online bets", Interview regarding compulsive gambling, Ventura County Star, Ventura, CA

7/04 "Psychopharmacology, Practice & Pitfalls in the General Hospital & ICU patient", Grand Rounds, UPMC-St. Margaret's Hospital, Aspinwall, PA

6/04 Interview regarding serial killer, Eugene McWatters, Port St. Lucie News, Pt. St. Lucie, FL

4/04 Testimony regarding urine drug testing and confounding physiological fluid balance abnormalities in professional football players, NFL League Headquarters, New York, NY

3/04 Interview regarding Asperger's Syndrome and the Robert Durst Murder Trial, "48 hours" show, ABC TV, New York, NY

2/04 "The role of the Forensic Neuropsychiatrist in Civil & Criminal court proceedings", Duquesne Law School/Forensic Science program, Pittsburgh, PA

1/04 "Gambling Addiction & Gambling TV", interview, FoxNews.com, New York, NY

11/03 "Is there a common set of characteristics among serial killers", interview regarding the apprehension of Green River serial killer Gary Ridgeway, Agence France Presse Wire Service, Los Angeles, CA

11/03 "Gambling Addiction", interview regarding this disorder, The Newark review, Newark, Delaware

10/03 Radio interview regarding Rush Limbaugh and opiate addiction in professionals, KABC radio station, Los Angeles, California

9/03 "Drug and Alcohol Detoxification in the medical inpatient", Family Practice Residency Teaching lecture, UPMC-St. Margaret's Hospital, Aspinwall, PA

9/03 "The use of anxiolytics, antipsychotic agents and antidepressants in the ICU", Grand Rounds, UPMC-St. Margaret's Hospital, Aspinwall, PA

8/03 Radio interview regarding serial sniper in Charleston WV, and the psychiatric profile of serial killers, KMSO radio station, Kansas City, Kansas

7/03 "Mother of Townsend Boy: 'there's no need for arrest'", interview regarding Asperger's Syndrome, The Middletown Transcript, Middletown, Delaware

5/03 "Breakthroughs in Burn treatment saves Lives", interview regarding current Burn Trauma treatment in US, Buenos Aires Herald, Buenos Aires, Argentina

5/03 "Amnesia", interview regarding US soldier Pfc. Jessica Lynch and her reported amnesia after Iraqi War capture, Chicago Tribune, Chicago Illinois

4/03 "Gulf War Syndrome", radio interview regarding Gulf War Syndrome and its' clinical effects, National Radio Chain, Colombia, South America

4/03 "The Mystery of Nigel Smith", interviewed regarding homeless man with psychogenic amnesia, Post & Courier Newspaper, Charleston, SC

3/03 "After Kuwait grenade incident, 101st Airborne Soldiers fight new fear", interviewed regarding grenade attack by US soldier on comrades in Kuwait during 2nd Gulf War, Stars & Stripes Magazine, Washington, DC

2/03 "New Techniques Proving Vital for Burn Patient's", interviewed regarding Rhode Island Night-Club Fire, Boston Globe Newspaper, Boston, MA

1/03 "The Death Penalty in America, aftermath of the Illinois Governor's Decision", interview, WLIE Radio, Long Island, NY

11/02 "Rational Use of Chemical Restraints in the Agitated ICU patient", Saint Margaret's Memorial Hospital, Department of Critical Care Medicine, Pittsburgh, Pa.

10/02 "Gulf War Syndrome & Violent Behavior" – interview, Canadian Public Broadcasting Channel, Toronto , Canada

9/02 "Desperate Mom kills son to save self", interview regarding addiction and codependency in genesis of crime, Salt Lake City Tribune, Salt Lake, UT

3/02 "Psychiatric Assessment of the 'Sexually Violent Predator', Practice & Pitfalls", Pennsylvania Association of Criminal Defense Lawyers, Pittsburgh, Pa.

1/02 "Psychiatric Issues in Federal Sentencing Downward Departure",
Pennsylvania Association of Criminal Defense Lawyers, Valley Forge, Pa.

7/01 "Fibromyalgia", Pennsylvania Bar Institute - Pittsburgh, Pa.

6/01 "Fibromyalgia", Pennsylvania Bar Institute - Philadelphia, Pa.

8/00 CLE Lecture - Lawyers Concerned for Lawyers - PA Chapter "Modern Rx"
Pittsburgh, PA

6/00 Invited Presentation to Pa. Senate Subcommittee on Youth & Aging -
"The Legal Rights of the Mentally Ill as pertains to Involuntary Commitment
and gun ownership"; Public Hearing on Violence & Mental Illness,
Sponsor : State Senator Murphy, Allegheny County Courthouse, Pittsburgh, Pa

10/99 CME Lecture – Medicolegal Seminar
"Dynamic Neuroimaging, the state of the art", Pittsburgh, Pa

8/99 CLE Lecture – Lawyers Concerned for Lawyers –PA Chapter
"Stress, Burnout, Addiction and Depression in Professionals",
Pittsburgh, PA

5/99 CME Lecture -Allegheny County Workers Compensation Information
Exchange "Demographic & Behavioral Predictors in the Acutely Injured
Worker" Pittsburgh, Pa

4/99 CLE Lecture – Lawyers Concerned for Lawyers –PA Chapter
"Addiction Issues and Downward Departure under Federal
Sentencing Guidelines", Pittsburgh, Pa

3/99 CLE Lecture – Allegheny County Bar Association –
"Closed Head Injury, New Developments", Pittsburgh, Pa

11/ 98 Grand Rounds – UPMC/Passavant Hospital –
"Psychopharmacology in the Critically Ill Patient", Pittsburgh, Pa.

11/ 98 Teaching Grand Rounds – St. Margaret's Mem. Hospital –
"Emergency Psychiatry, Principles & Practice", Pittsburgh, Pa.

10/ 98 Grand Rounds – St. Margaret's Mem. Hospital –
"Invasive Psychiatry -- management of the ICU patient with agitation",
Pittsburgh, Pa.

10/ 98 Seminar – Morgantown, WV. – "Daubert Issues in Neuropsychiatry",

presented at CLE Seminar for Northern West Virginia.

5/98 "Psychiatric Implications of Impairment", presented at *Worker's Compensation Impairment Evaluation: Using the 4th Edition of the AMA Guidelines*, Pennsylvania Orthopedic Society, Philadelphia, Pa.

9/97 Teaching Grand Rounds: "Management of Agitation in The ICU" - St. Margaret's Memorial Hospital. Pittsburgh, Pa.

6/97 Grand Rounds - Shadyside Hospital, "Depression in the Medically Ill"; Pittsburgh, PA

6/97 Presenter, CLE/CME Seminar, Duquesne University School of Law , "McN'aughton meets Buck Rogers, Forensically proving cognitive impairment into the 21st century ", Pittsburgh., PA.

3/97 Presenter, CLE/CME Seminar - , "Depression, Brain Injury and Reflex Sympathetic Dystrophy", Erie, PA.

1/97 Presenter, CLE/CME Seminar - "Tort Aspects of Neurotoxicology", Pittsburgh, PA.

11/96 Presenter, Pennsylvania Defense Institute CLE/CME course, "Depression, Brain Injury and Reflex Sympathetic Dystrophy", Pittsburgh, PA.

9/96 Grand Rounds-Harmarville Rehabilitation Center, "Pharmacology of the Newer Antidepressants", Pittsburgh, PA.

4/96 Presenter, Pennsylvania Association of Criminal Defense Lawyers 1996 Spring Meeting & CLE/CME Seminar, "The Effective Use of Psychiatric Evidence" Pittsburgh, PA

4/94 Presenter, Annual American Trauma Society Conference, Pennsylvania Division, "Neuropsychiatric Determinants of Repetitive Injury", Pittsburgh, PA

7/93 Grand Rounds-Harmarville Rehabilitation Center, "Treatment of Geriatric Depression"; Pittsburgh, PA.

4/93 Presenter - Annual American Trauma Society Conference, Pennsylvania Division, "Neuropsychiatric Determinants of Repetitive Injury", Pittsburgh, PA

4/93 Grand Rounds - St. Francis Hospital, "Depression in the Medically Ill"; Pittsburgh, PA

10/92 Grand Rounds - University of Pittsburgh Medical Center Department of Critical Care Medicine, "Acute Drug Withdrawal"; Pittsburgh, PA.

9/92 Medical Grand Rounds - University of Pittsburgh Medical Center, "Acute Drug Withdrawal"; Pittsburgh, PA.

9/92 Grand Rounds - Center for Emergency Medicine, "Acute Drug Withdrawal"; Pittsburgh, PA.

5/92 Grand Rounds - Montefiore University Hospital Department of Toxicology/Emergency Medicine "Acute Drug Withdrawal"; Pittsburgh, PA.

4/92 Grand Rounds - University of Pittsburgh Medical Center, Department of Critical Care Medicine, "Stress Management in the Critical Care Setting"; Pittsburgh, PA.

3/92 Eastern Emergency and Trauma Forum - University of Pittsburgh Medical Center, Departments of Trauma and Emergency Medicine "Neuropsychiatric Determinants of Repetitive Traumatic Injuries"; Pittsburgh, PA

1992 Lecturer, Psychiatry Rotation, to third year Medical Students; University of Pittsburgh Medical Center, Pittsburgh, PA

10/91 Grand Rounds - University of Pittsburgh Medical Center, Department of Critical Care Medicine, "Differential Diagnosis and Management of Agitation in the Critical Care Setting"; Pittsburgh, PA.

10/91 Teleconference - University of Pittsburgh Medical Center, Department of Toxicology/Emergency Medicine, "Assessment and Management of the Violent Patient"; Pittsburgh, PA.

9/91 Trauma Conference - University of Pittsburgh Medical Center, Department of Surgery, Trauma Service "Neurobiological Antecedents of Repetitive Traumatic Injury"; Pittsburgh, PA.

12/90 Grand Rounds - New York Hospital, Department of Psychiatry, "Psychiatric Management of the Severely Burned Patient"; New York, NY.

TEACHING:

2003 -2009 Co-developer/lecturer Neuropsychiatry/Neurotoxicology curriculum for ICU rotation @ St. Margaret's Memorial Hospital-- Family Practice Residency Curriculum

1997 -2003 Clinical Preceptor, Western Psychiatric Institute & Clinic & St. Margaret's Memorial Hospital - Emergency Psychiatry Curriculum

1994-2003 Volunteer faculty, University of Pittsburgh Medical Center - Psychiatry Residency

Curriculum

1997 -2002 Guest Lecturer, Shadyside Hospital - Family Practice Curriculum

1992-95 Curriculum Director, WPIC Office of Residency Training didactic curriculum;
University of Pittsburgh Medical Center, Pittsburgh, PA

1992-1995 Program Development Consultant, Various Regional Health Care Organizations

1991-95 Supervisor, Psychiatric Residents and Medical Students on the Psychiatric
Consultation-Liaison Service/Program; University of Pittsburgh Medical Center,
Pittsburgh, PA

1991-95 Examiner, Mock Board Examination as a component of the Residency Training
Program at Western Psychiatric Institute and Clinic; University of Pittsburgh
Medical Center, Pittsburgh, PA.

RESEARCH: Past Grants

<u>Grant Number (Funded)</u>	<u>Grant Title</u>	<u>Role in Project and % Effort</u>	<u>Years Inclusive</u>	<u>Source</u>
<i>[Internal Seed Funds]</i>	Undetected Alcoholism in the Acute Burn Trauma Patient	Principal Investigator; 50% FTE, 0% salary support	1990-1991 \$8,000	NY Hospital/ Payne Whitney Clinic Training Grant
<i>[Internal Seed Funds] [2-90871]</i>	Beta Endorphin Levels in Acutely Traumatized Patients, Presbyterian	Principal Investigator; 20% effort, 0% salary support	12/91-11/92 \$9,000	Univ. Pittsburgh Medical Center - Seed Grant

University
Hospital

1-T15- MH19883-01	HIV Infection and AIDS	Co-Principal Investigator; 10% effort, 10% salary support [<i>L</i> <i>Frank PhD,</i> <i>P.I.</i>]	8/92-7/95 \$157,211 (yrs 01 & 02)	NIMH Mental Health Care Provider Training Grant [University of Pittsburgh Dept Epidemiology]
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RESEARCH: Presentations

3/91 Young Investigators Poster Session - American Psychiatric Association Annual Meeting, "Undetected Alcohol Related Burn Trauma"; Washington, DC.

6/91 Grand Rounds - New York Hospital, Department of Psychiatry, "Undetected Alcohol Related Burn Trauma"; New York, NY.

5/93 Scientific Program Poster Session - American Psychiatric Association Annual Meeting, "Pain Perception and Beta Endorphin Level in Trauma"; San Francisco, CA

EXHIBIT 19

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MINNESOTA

Larry E. Smith as)
trustee for the Heirs)
and Next of Kin of)
David Cornelius Smith,)
)
)
Plaintiff,)
)
vs.) Case No.
) 11-cv-03071 (SRN/JJK)
Timothy Gorman and)
Timothy Callahan,)
acting in their)
individual capacities)
as Minneapolis police)
officers, and the City)
of Minneapolis,)
)
Defendants.)

VIDEOTAPE DEPOSITION OF
LAWSON F. BERNSTEIN, JR., M.D.

February 5, 2013

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WITHOUT AUTHORIZATION FROM THE CERTIFYING
AGENCY

	Page 2
<p>1 VIDEOTAPE DEPOSITION OF LAWSON F. BERNSTEIN, 2 JR., M.D., a witness herein, called by the 3 Plaintiff for examination, taken pursuant to 4 the Federal Rules of Civil Procedure, by and 5 before Ronda J. Weinell, a Registered 6 Professional Reporter and Notary Public in and 7 for the Commonwealth of Pennsylvania, at the 8 law offices of Meyer, Unkovic & Scott, 9 1300 Oliver Building, 536 Smithfield Street, 10 Pittsburgh, Pennsylvania, on Tuesday, 11 February 5, 2013, at 8:31 a.m.</p> <p>13 ----- 14 COUNSEL PRESENT: 15 For the Plaintiff: 16 Robert Bennett, Esq. 17 and Jeffrey S. Storms, Esq. 18 Gaskins Bennett Birrell Schupp LLP 19 333 South Seventh Street, #2900 20 Minneapolis, MN 55402 21 For the Defendants: 22 Burt T. Osborne, Assistant City Attorney 23 City of Minneapolis 24 Office of City Attorney 25 350 South Fifth Street - Room 210 Minneapolis, MN 55415</p>	Page 4
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<p style="text-align: right;">Page 6</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 THE VIDEOGRAPHER: Going off 3 the record at 8:32 a.m. 4 (Off the record.) 5 (Deposition Exhibit Nos. 1 6 through 5 were marked for identification.) 7 THE VIDEOGRAPHER: We're back 8 on the record at 8:34 a.m. 9 Q. Dr. Bernstein, you've had your 10 deposition taken many, many times before; 11 correct? 12 A. Correct. 13 Q. And I've marked five exhibits, and 14 I'd just like to identify them for the record, 15 please. What is Exhibit 1? 16 A. Exhibit 1 is an advertisement I have 17 on a website called HGExperts.com, which is a 18 forensic search engine for medical experts. 19 No. 2 -- 20 Q. That's a three-page document? 21 A. Yes. I believe it is. No. 2 is a 22 copy of my current forensic fee agreement. 23 That's three pages. 24 No. 3 is my current CV, which I 25 believe is 15 pages in length. 16.</p>	<p style="text-align: right;">Page 8</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 had some experience in these areas. 3 A. Right. That is correct. 4 Q. Syphilis? 5 A. Neurosyphilis, specifically, but 6 that's correct. 7 Q. Tobacco? 8 A. As an addictive disorder. 9 Q. There are about 105 of these, aren't 10 there? 11 A. I believe so, 105 five search terms, 12 correct. 13 Q. And the rest of it -- 14 A. Actually, are there 105? 15 Q. I think so. 16 A. Well, we can add it up during the 17 break, but thank you. 18 Q. I think you did it in another 19 deposition, as well. 20 A. Okay. 21 Q. I counted them. Did you take any 22 off after the -- 23 A. I don't think so. 24 Q. And the Exhibit 2 is your fee 25 schedule notification and cancelation policy;</p>
<p style="text-align: right;">Page 7</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 No. 4 is a case list, which is four 3 pages in length, and No. 5 is a xerographic 4 copy of my report and the list of records that 5 I reviewed as part of the preparation of that 6 report. 7 Q. The report is for your opinions in 8 this case? 9 A. Yes, sir. 10 Q. Starting with Exhibit 1, the 11 information on this exhibit was provided by 12 you? 13 A. Correct. The areas of expertise is 14 from a list that's provided by the website 15 folks, but I did check the boxes that were 16 applicable. 17 Q. So, for example, you checked the 18 box, when it says sexual addiction, you checked 19 that? 20 A. Yes, sir. 21 Q. Serial killers? 22 A. Well, I've worked on death row and 23 treated more than a few serial killers, that's 24 correct. 25 Q. I assumed you checked it because you</p>	<p style="text-align: right;">Page 9</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 correct? 3 A. Yes, sir. 4 Q. And you stated your hourly fees for 5 file review, trial preparation at \$500 or 6 \$550 per hour; is that correct? 7 A. Right. Depending on how quickly the 8 turnaround is. 9 Q. The more emergent it is, the more 10 you up the rate? 11 A. Correct. 12 Q. The IME report fee, does that 13 include the file review, or is that a second 14 charge for the report? 15 A. No. That's -- no. That would be 16 subsumed within that total fee. 17 THE COURT REPORTER: Could we 18 go off the record for a second. 19 THE VIDEOGRAPHER: Going off 20 the record at 8:38 a.m. 21 (Off the record.) 22 THE VIDEOGRAPHER: We're back 23 on the record at 8:51 a.m. 24 BY MR. BENNETT: 25 Q. We've been dealing with some</p>

<p style="text-align: right;">Page 10</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 technical issues, but I think I remember where 3 I am. We were talking about your manner of 4 charging for this case, generally and for this 5 case. Exhibit 2 defines what it is in cases 6 generally; correct?</p> <p>7 A. Yes, sir.</p> <p>8 Q. And it is the fee agreement that is 9 part of your agreement with the defendants in 10 this case?</p> <p>11 A. Yes.</p> <p>12 Q. Essentially, though, what you're 13 charging is \$500 an hour for every hour you 14 work on this case, plus the fee for the 15 deposition?</p> <p>16 A. Correct.</p> <p>17 Q. Do you know how much time you've 18 spent on this case to date?</p> <p>19 A. Including the preparation for today, 20 I would say it's in the neighborhood of 30 to 21 40 hours.</p> <p>22 Q. And that \$500 fee includes the 23 preparation of a report?</p> <p>24 A. Yes, sir.</p> <p>25 Q. Exhibit 3 is your current CV?</p>	<p style="text-align: right;">Page 12</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 Continental Wingate Capital Organization, '83 3 to '87?</p> <p>4 A. On a part-time basis.</p> <p>5 Q. Yeah, I notice you were going to 6 medical school then.</p> <p>7 A. Correct.</p> <p>8 Q. Correct? What is Continental 9 Wingate Capital Corporation?</p> <p>10 A. It was an entity that bought 11 historically significant properties, turned 12 them into Section 8 housing, and then 13 syndicated that, i.e., sold shares in that for 14 the purposes of investment and for the tax 15 benefits that accrued from that type of 16 investment at that time.</p> <p>17 And I wrote some of their marketing 18 material.</p> <p>19 Q. If you look back at Exhibit 1, you 20 say there in the first page that you are a 21 Board certified forensic neuropsychiatrist.</p> <p>22 A. Correct.</p> <p>23 Q. I looked at your CV, and I see you 24 were Board certified, at least in your CV, you 25 were certified by the American Board of</p>
<p style="text-align: right;">Page 11</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 A. Yes.</p> <p>3 Q. And I'd like to go over some things 4 in that, if you will, that I found interesting.</p> <p>5 A. Okay.</p> <p>6 Q. What year were you born, sir?</p> <p>7 A. '57, 1957.</p> <p>8 Q. Where was that?</p> <p>9 A. In New York City.</p> <p>10 Q. And you graduated from high school 11 in?</p> <p>12 A. '75.</p> <p>13 Q. And then I note that then you were 14 the principal in Loan Star Trucking and Freight 15 Company.</p> <p>16 A. Which means I owned a truck, that's 17 correct.</p> <p>18 Q. And you did that for three years?</p> <p>19 A. As well as some other things, yes.</p> <p>20 I had other blue collar jobs, for lack of a 21 better term.</p> <p>22 Q. You were a union organizer for what 23 union?</p> <p>24 A. District 65, Textile Workers.</p> <p>25 Q. And a marketing representative for</p>	<p style="text-align: right;">Page 13</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 Psychiatry and Neurology.</p> <p>3 A. Correct.</p> <p>4 Q. In both?</p> <p>5 A. No, no, no. It's a joint board, and 6 there are two certifications. It's psychiatry 7 or neurology, and I was Board certified in 8 psychiatry.</p> <p>9 Q. That's what I thought. Okay. And 10 you're also certified by the American Board of 11 Forensic Medicine?</p> <p>12 A. Correct.</p> <p>13 Q. And a diplomat of the American Board 14 of Forensic Examiners?</p> <p>15 A. Yes, sir.</p> <p>16 Q. You are not Board certified in 17 neuropsychiatry, are you?</p> <p>18 A. I've not done a fellowship and sat 19 for the exam, that's correct.</p> <p>20 Q. The neuropsychiatry has -- actually, 21 the Board that deals with that is entitled 22 Behavioral Neurology and Neuropsychiatry; 23 correct?</p> <p>24 A. I believe so.</p> <p>25 Q. And that is jointly accredited</p>

	Page 14		Page 16
1	Dr. Bernstein - by Mr. Bennett	1	Dr. Bernstein - by Mr. Bennett
2	through the United Council for Neurologic	2	Clinical Psychopharmacology?
3	Subspecialties and the American Board of	3	A. No.
4	Psychiatry and Neurology; correct?	4	Q. How about the American
5	A. Yes.	5	Psychopathologic Association?
6	Q. And you do not have that Board	6	A. No.
7	certification?	7	Q. How about the American College of
8	A. No.	8	Psychosocial Research?
9	Q. Nor do you have the American	9	A. No. That would be very far afield
10	Neuropsychiatric Association Membership;	10	from what I do.
11	correct?	11	Q. Have you ever been the board member
12	A. No, sir.	12	or had any position of leadership in the
13	Q. You went to undergraduate, got your	13	American Psychiatric Association?
14	baccalaureate at Hunter College in the City	14	A. I ran a committee for the American
15	University of New York?	15	Academy of Directors of Psychiatric Group
16	A. Correct.	16	Residency Training regarding managed care and
17	Q. In '83?	17	education, but I don't think that was also an
18	A. Correct.	18	APA affiliated committee, so I would have to
19	Q. And you, like I, was an English	19	say no.
20	major?	20	Q. Do you have any postdoctoral
21	A. And classics, Latin.	21	training?
22	Q. Then you went to Cornell University	22	A. As in fellowship training after
23	for medical school?	23	residency?
24	A. Correct.	24	Q. Yes.
25	Q. And it says Cornell University in	25	A. No.
	Page 15		Page 17
1	Dr. Bernstein - by Mr. Bennett	1	Dr. Bernstein - by Mr. Bennett
2	New York, New York. Is that -- the Cornell I'm	2	Q. You've been a clinical instructor in
3	thinking of is in Ithaca, New York.	3	psychiatry at the University of Pittsburgh
4	A. Right. People always say what do	4	School of Medicine?
5	you think of Ithaca, and I say I've never been	5	A. Correct.
6	there. The medical school is actually in New	6	Q. And you've also taught at the
7	York City.	7	Department of Family Practice at the University
8	Q. You did your internship at New York	8	of Pittsburgh School of Medicine; correct?
9	Hospital?	9	A. Correct.
10	A. Correct.	10	Q. At this time how is it that you --
11	Q. And your residency in psychiatry at	11	what professions or businesses do you work in
12	New York Hospital, as well; correct?	12	presently?
13	A. Yes.	13	A. I have my own professional
14	Q. You became Board certified in	14	corporation, Lawson F. Bernstein, M.D., PC.
15	psychiatry in 1992?	15	Q. And that is a forensic and you say
16	A. Correct.	16	neuropsychiatric consulting practice?
17	Q. Are you a member of the American	17	A. Correct.
18	College of Psychiatrists?	18	Q. And in your CV you say you have an
19	A. I'm not sure I've ever heard of that	19	expertise in the assessment and treatment of
20	organization.	20	brain injury, seizure disorders, stroke, toxic
21	Q. How about the International Society	21	environmental exposure, chronic pain condition,
22	for the Study of Personality Disorders?	22	addiction, and other neurological and
23	A. No. Most assuredly I am not a	23	neuropsychiatric conditions; is that correct?
24	member of that organization.	24	A. Correct.
25	Q. How about the American Society of	25	Q. Do you still perform work as a

<p style="text-align: right;">Page 18</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 consultant for the Department of State, 3 Pennsylvania Bureau of Professional and 4 Occupational Affairs?</p> <p>5 THE COURT REPORTER:</p> <p>6 Occupational --</p> <p>7 MR. BENNETT: Affairs.</p> <p>8 A. Yes. I have a matter that I will be 9 appearing before them Thursday of this week.</p> <p>10 Q. How much of your time is taken up in 11 this position?</p> <p>12 A. It varies. I probably do one to two 13 independent assessments for them a month, and 14 then occasionally there will be an 15 administrative law hearing regarding somebody's 16 license that I might have to testify at.</p> <p>17 I assess healthcare professionals 18 for which there are allegations that they're 19 unfit to practice regarding neurological, 20 psychiatric, or substance abuse issues. That 21 would be my answer.</p> <p>22 Q. Okay. On an average how many hours 23 a month do you spend doing that?</p> <p>24 A. Three.</p> <p>25 Q. And then it also says you're a</p>	<p style="text-align: right;">Page 20</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 Q. How much time do you devote to that 3 on a monthly basis?</p> <p>4 A. It really varies. The next couple 5 of months will be quite a bit, because I have 6 to give a couple of lectures and participate in 7 a mock trial experience. So that's probably 8 going to be for March, April, and May, maybe 9 ten hours a month, maybe more.</p> <p>10 The Cyril Wecht thing is sort of hit 11 and miss. Depends what programs they're 12 putting on. If they're putting on something 13 that they want me to lecture in, it may be ten 14 hours in a month, as I get ready to do that, 15 and then maybe nothing for eight or nine 16 months.</p> <p>17 Q. So on average or during the course 18 of a year, it's not very much time for either 19 one of them?</p> <p>20 A. Well, I mean, it seems like a fair 21 amount of time at the time it's going on. I 22 suppose if you averaged it out, yes, it would 23 be a low amount of time.</p> <p>24 Q. I mean, in total, would it be a 25 week's worth of bills, 40 hours?</p>
<p style="text-align: right;">Page 19</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 forensic psychiatric consultant for the Office 3 of Public Defender of Allegheny County, Court 4 of Common Pleas, Juvenile Division, and Family 5 Division, Orphans' Court, Allegheny County?</p> <p>6 A. Correct.</p> <p>7 Q. How much time do you spend on a 8 monthly basis doing that?</p> <p>9 A. There are months at a time where I 10 might not do anything with them, and then if 11 I'm involved in a case, it might be a few hours 12 in a given month.</p> <p>13 Q. So your predominant work activity is 14 within and for Lawson F. Bernstein, PC, or 15 professional corporation?</p> <p>16 A. Yes. I'm not anybody's employee, 17 that's correct.</p> <p>18 Q. Are you on staff at any hospitals 19 right now?</p> <p>20 A. At this time, no.</p> <p>21 Q. Are you teaching anywhere right now?</p> <p>22 A. I teach at the Duquesne University 23 Law School in their neuroscience in the law 24 curriculum and at the Cyril Wecht Forensic 25 Institute.</p>	<p style="text-align: right;">Page 21</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 A. I don't bill. That's all --</p> <p>3 Q. A week's worth of time? Excuse me.</p> <p>4 A. Yeah. Maybe a week, week and a 5 half.</p> <p>6 Q. Okay. So your predominant 7 occupational activity is forensic and 8 neuropsychiatric consulting?</p> <p>9 A. Right. I treat patients, and I do 10 forensic consulting.</p> <p>11 Q. And how many patients do you 12 currently treat?</p> <p>13 A. With the understanding that some of 14 these people are folks I see maybe four times a 15 year, I don't know, a couple hundred patients.</p> <p>16 Q. Okay. Exhibit 4 is your list of 17 testimony?</p> <p>18 A. Yes.</p> <p>19 Q. And WC I would take to mean workers' 20 comp?</p> <p>21 A. Yes.</p> <p>22 Q. PI is personal injury?</p> <p>23 A. Yes.</p> <p>24 Q. Criminal is criminal defense?</p> <p>25 A. Well, sometimes plaintiffs or</p>

<p style="text-align: right;">Page 22</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 prosecution, I should say. 3 Q. Divorce speaks for itself. Med mal 4 speaks for itself, I take it. But it's a 5 variety of criminal and civil testimony. How 6 much as a percentage of your time do you spend 7 getting ready to and testify? And that would 8 include your file review. 9 A. Right. I would say it can be 10 anywhere from 25 to 35 percent of my time. 11 Q. Have you ever published any papers 12 specifically related to schizophrenia? 13 A. No. Well, let me be encyclopedic in 14 my answer. I wrote a book chapter on burn 15 trauma and psychiatric disease which contained 16 a section on psychotic disorders as a risk 17 factor for self-immolation, but other than 18 that, no. 19 Q. How about schizoaffective disorders? 20 A. No. Same answer. 21 Q. Why would it be the same answer? 22 A. People with psychotic spectrum -- 23 when you look at those people who purposely set 24 themselves on fire, which is a unique clinical 25 group, you see an overrepresentation of</p>	<p style="text-align: right;">Page 24</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 venue. But 95 percent of the time that's what 3 that is. 4 Other state entities, I would say 5 it's generally for the defense, I'd say 75 6 percent of the time. For the federal entities, 7 of late, it's been primarily prosecution, I 8 would say 75 percent of the time. 9 Q. So you would know, if I said the 10 term to you record evidence, you would know 11 what I was talking about? 12 A. I think I would know what you're 13 talking about, but I would ask you to define 14 the term. 15 Q. Well, I'd look at record evidence as 16 the things that generally would become exhibits 17 or potential exhibits in any civil action, 18 things you would look at forensically to make 19 determinations, come to judgments and 20 professional opinions. 21 A. Correct. I might term it as 22 documents or other information that might be 23 produced as part of the discovery process but, 24 yes, I understand the term as you've defined 25 it.</p>
<p style="text-align: right;">Page 23</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 individuals with psychotic spectrum disorders. 3 Q. And a fair amount of your writing 4 has been devoted, at least in some part, to the 5 intersection of burns and psychiatry? 6 A. And traumatic injury and psychiatry 7 and substance abuse as a sort of fellow 8 traveler of that clinical group. 9 Q. All right. When you testify for the 10 government, that is, a federal or state agency, 11 is it usually related to prosecution of 12 criminal matters? 13 A. Let me think. Did you say federal 14 government? 15 Q. Federal or state. 16 A. Okay. 17 Q. If you want to break it up into 18 federal and then give that answer and state, 19 however -- 20 A. Sure. Well, state would include the 21 Bureau of Professional Occupational Affairs 22 thing, which I guess when we consider 23 prosecution, and in that venue it's always for 24 them. Well, no. I've done one or two cases 25 that weren't for them that ended up in that</p>	<p style="text-align: right;">Page 25</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 Q. Okay. When were you first contacted 3 about this case? 4 A. That's a good question. I apologize 5 for this. I should know this. Sometime in 6 2011. 7 Q. Your report is dated December 7th, 8 2012, and it would have been more than a year 9 prior to your -- 10 A. No. I'm sorry. It would have been 11 sometime in 2012. My mistake. 12 Q. Do you have any idea, with reference 13 to your report dated 12/7/12, how much before 14 it would be -- 15 A. Months. 16 Q. Who contacted you? 17 A. I don't recall. 18 Q. And who decided what it was that you 19 would be paid to review and to come to your 20 professional judgments? Is that based on the 21 contract that you commonly used as Exhibit 2? 22 A. Yes. Whether that was read and 23 signed by an individual within the professional 24 entity that is defending the matter or whether 25 they generated some sort of contract through</p>

<p style="text-align: right;">Page 26</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 their office that replicated or substantially 3 replicated my fee agreement, I don't recall. 4 But, yes, my fee -- 5 Q. Do you have a signed contract? 6 A. I'd have to go back to the office 7 and look. I imagine I have something, because 8 I won't get involved unless there is some 9 written agreement. But many times when I deal 10 with a local, state, or federal entity, they'll 11 have to put it within a document that they 12 would use for the purposes like a purchase 13 order, sort of, and that may be the case here, 14 as opposed to somebody in the defendant's 15 practice, law practice that's defending the 16 matter actually signing the fee agreement. I'm 17 not sure which it is. 18 Q. What was the assignment, as you 19 understood it? 20 A. To review the universe of 21 information available regarding the matter and 22 to respond to certain questions that were posed 23 of me by the attorneys defending the matter. 24 Q. So that was -- the questions that 25 were answered in your report are questions that</p>	<p style="text-align: right;">Page 28</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 A. No. 3 Q. Who chose what to give to you to 4 review? You or the defense counsel? 5 A. What I communicated to defense 6 counsel was that it would be my preference to 7 have as much of the discovery that they would 8 care to give me with the understanding that 9 more is generally better than less. 10 What was sent to me was voluminous. 11 Upon reviewing it, I did not feel there was 12 anything that appeared to be lacking, so I did 13 not ask for anything further. 14 Q. Did you know the universe of 15 discovery that was available? 16 A. No, I did not. 17 Q. So how would you know what to ask 18 for within the universe? 19 A. Generally speaking, what I'm looking 20 for are clinical records, if there are expert 21 reports, that sort of thing, other information 22 that's generated by the discovery process, any 23 video material that might be relevant to the 24 matter at hand. Those would all be -- that 25 would all be information I would want to see</p>
<p style="text-align: right;">Page 27</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 they came up with? 3 A. Correct. 4 Q. And not questions that you came up 5 with? 6 A. No. 7 Q. Were there any questions that you 8 chose not to answer that are posed? 9 A. No. Let me think for a second. Was 10 there anything posed of me that I thought was 11 outside my area of expertise? 12 Q. That's not what I asked. 13 A. I know, but it would sort of be on 14 point. That's why I'm thinking out loud. And 15 the answer to that is no. 16 Q. Okay. Do you believe that the 17 mentally ill, particularly people who have 18 schizophrenia or schizoaffective disorder, are 19 worthless? 20 A. No. Hardly. 21 Q. Do you think their lives have value? 22 A. All life has value. 23 Q. Did your assignment change at all 24 after you were hired? Did it morph into 25 something different?</p>	<p style="text-align: right;">Page 29</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 and that was present. 3 Q. Well, there's some things, if we go 4 to your report, it said David C. Smith, records 5 review; correct? 6 A. Yes, sir. 7 Q. I don't see -- is this the list, 8 complete list of what you did review? 9 A. I don't believe I've received 10 anything else subsequent to this list being 11 generated. 12 Q. And you meant it to be complete when 13 you drafted it? 14 A. Yes, sir. 15 Q. Because you knew that there would be 16 fellows like me that would cross-examine you. 17 A. That is one reason to be complete. 18 Q. And you figured I'd do my homework? 19 A. Yes, in fact, I did. 20 Q. I don't see any record here that you 21 looked at either the pen camera video, the YMCA 22 video, or the taser video. 23 A. I'm so sorry if that's not in here, 24 and I truly apologize for that. I have the pen 25 camera video.</p>

<p style="text-align: right;">Page 30</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 Q. Do you have the YMCA video? 3 A. I don't think I've seen that. 4 Q. How about the taser video? 5 A. I didn't know that such a thing 6 existed. 7 Q. So we're one for three on the video 8 evidence? 9 A. And I apologize for the fact that is 10 not listed here. That is my error. 11 Q. There are some other things that 12 aren't in there that I want to talk to you 13 about, too. 14 A. All right. 15 Q. So you would have been in charge of 16 talking to the city attorney, and the city 17 attorney would be the person who transmitted 18 that pile of materials over to your -- which is 19 stage left, I guess, in the video. I don't see 20 that you reviewed any deposition transcript, 21 for example, of David's mother's deposition. 22 A. I did not see that. 23 Q. Nor any of his siblings who were 24 also deposed by Mr. Osborne? 25 A. Those are not documents that I've</p>	<p style="text-align: right;">Page 32</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 party not reflected in the documents? No. 3 Q. Do you think it would have been 4 important for your analysis and in coming to 5 your professional opinions and judgments to 6 look at the deposition of his treating 7 psychiatrist? 8 A. You know, the records are so 9 voluminous in this matter and the documentation 10 is so thorough going, if such a document 11 exists, if such deposition exists, I would like 12 to see it. But I don't think it would 13 substantively change my opinion, unless the 14 gentleman's opinions are different than what is 15 reflected in the records that I reviewed. 16 Q. But without looking at it, you 17 wouldn't know? 18 A. That is correct. 19 Q. For example, if Dr. Zimmerman or 20 Maureen Glover touched on areas that were 21 pertinent to the answers to your questions, 22 would that be one of the things you would want 23 to know? 24 A. Would that be one of the things I 25 would want to know.</p>
<p style="text-align: right;">Page 31</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 seen. 3 Q. Did you interview his longtime girl 4 friend Josephine -- how do you say that name? 5 MR. STORMS: I think it's 6 Oluuch. 7 Q. Oluuch? 8 A. No. 9 Q. O-L-U-U-C-H. Did you even know that 10 David had a longtime girl friend? 11 A. Yes. 12 Q. I also note that there is the 13 deposition transcript of Dr. Joshua Zimmerman, 14 his treating psychiatrist. It was not on your 15 list, either. 16 A. I have not seen that. 17 Q. Nor Maureen Glover, his veteran case 18 manager at Behavioral Health Care? 19 A. I have not seen that. 20 Q. Did you consult with or interview 21 anyone who personally knew David Smith? 22 A. Did I personally speak to any of the 23 authors of the multiple documents that I 24 reviewed? No. 25 Did I ask to speak to any third</p>	<p style="text-align: right;">Page 33</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 Q. Sure. 3 A. Certainly, I would be happy to 4 review their testimony, if it is substantively 5 different than what they reported in the record 6 would be my answer. 7 Q. Well, for example, if Dr. Zimmerman 8 testified under oath that they thought college 9 was an appropriate goal for him, would you want 10 to know that? 11 A. He's certainly entitled to whatever 12 opinion he might have. I must say the record 13 does not appear to be consistent with that. 14 But, sure, if that's an opinion that he holds, 15 I'd be happy to take a look at it. 16 Q. Have you ever heard the term 17 geographic cure? 18 A. Yes, I have heard that term. 19 Q. What does that mean to you? 20 A. It's generally a term of art that 21 refers to individuals with drug or alcohol 22 problems who move to a different locale, 23 distant from where they live with the idea that 24 this move will somehow magically cure the drug 25 and/or alcohol problem.</p>

<p style="text-align: right;">Page 34</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 Q. Well, I've read your report in great 3 detail, and I want to explore exactly what your 4 opinions are, and I want to focus on what 5 you're actually opining on to a reasonable 6 degree of medical certainty and things you're 7 merely mentioning in passing without having an 8 opinion to that level of certainty. Are we 9 communicating? Do you know what I'm looking 10 at?</p> <p>11 A. We are -- I do understand what you 12 just said.</p> <p>13 Q. Okay. And forensic psychiatry, 14 let's just talk about that for a moment before 15 we go into the opinions versus the nonopinions 16 section. But forensic psychiatry is -- how is 17 it different from ordinary psychiatry?</p> <p>18 A. Well, in clinical psychiatry one is 19 treating a patient and has a professional 20 relationship with that individual that has 21 certain -- one's alliances with the patient. 22 Forensic psychiatry is the application of 23 psychiatric diagnosis to issues in the law. 24 By definition, the relationship is 25 not with the patient. And there may be, in</p>	<p style="text-align: right;">Page 36</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 A. Okay. 3 Q. But I thought it was just a long way 4 of saying yes. 5 A. I've been known to do that. 6 Q. And you're good at it. 7 A. Well, that's very kind of you. 8 Q. So if you look at Exhibit -- you've 9 got your report in front of you? 10 A. I do. 11 Q. And we'll euphemistically refer to 12 it as Exhibit 5, and you can look at your 13 version, and I'll look at my version. 14 A. Yes, sir. 15 Q. You say at the beginning of the 16 second paragraph, "Briefly, this was a then 17 28-year-old man with a psychiatric history of 18 schizoaffective disorder, substance abuse, 19 antisocial personality disorder, and 20 longstanding treatment noncompliance." Is that 21 correct? 22 A. Yes. 23 Q. So what I wanted to know is that as 24 you sit here today and at the time you wrote 25 the report, are you forensically enforcing</p>
<p style="text-align: right;">Page 35</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 certain instances, may involve reviewing 3 voluminous records, but without the benefit of 4 actually evaluating the individual, 5 particularly if that individual is deceased. 6 Q. It's pretty hard to evaluate the 7 deceased, isn't it? 8 A. It is exceedingly difficult. 9 Q. But if you're going to be rigorous 10 in your forensic opinions, you have to apply 11 the same rules and strictures that govern, for 12 example, the diagnosis of mental disorders that 13 you would employ on the living, people you see; 14 correct? 15 A. The diagnostic criteria are the 16 same, whether they're applied in a clinical or 17 forensic setting. 18 Q. So the answer to my question is 19 really, yes, you have to be just as rigorous in 20 applying the diagnostic criteria to come to an 21 opinion about diagnosing someone forensically 22 as you do if you're treating them? 23 A. Referencing my prior answer without 24 repeating it, yes. 25 Q. Okay. And I understood your answer.</p>	<p style="text-align: right;">Page 37</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 these historical diagnoses, each of them? 3 A. In reviewing the records, I believe 4 that the diagnosis of schizoaffective disorder 5 is well documented, and I concur with it. The 6 diagnosis of substance abuse is well 7 documented, and I concur with it. 8 The statement long-term treatment -- 9 longstanding treatment noncompliance I believe 10 is well documented. 11 Q. That's not actually a disorder 12 but -- 13 A. It's a term of art. 14 Q. But you think that that is -- 15 there's record evidence that would amply 16 support that? 17 A. Right. The antisocial personality 18 disorder is open to debate. Frankly, even if 19 he doesn't have antisocial personality 20 disorder, it doesn't particularly change my 21 opinions, but I think that is more open to 22 debate than the others, which are not. 23 Q. What I'm getting at, it's only -- 24 I'm looking for your professional opinions and 25 judgments, and obviously it's only fair that</p>

<p style="text-align: right;">Page 38</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 you state the diagnosis is that you 3 forensically endorsed to a reasonable degree of 4 medical certainty; correct?</p> <p>5 A. In this colloquy, this was a 6 reflection of the record I reviewed, but it 7 wasn't proffered for the purposes of endorsing 8 it or not endorsing it. It was a way of 9 describing the individual and the events 10 surrounding that individual in that bullet 11 point kind of way.</p> <p>12 Q. Well, let's -- so what I heard you 13 say was that you believe that there's record 14 evidence that fully meets the criteria set 15 forth in DSM-IV-TR for schizoaffective 16 disorder?</p> <p>17 A. Yes, sir.</p> <p>18 Q. The same would be true for substance 19 abuse?</p> <p>20 A. Yes.</p> <p>21 Q. And is it your professional opinion 22 to a reasonable degree of medical certainty 23 that the diagnostic criteria for antisocial 24 personality disorder is met in this case?</p> <p>25 A. No. The conduct disorder with onset</p>	<p style="text-align: right;">Page 40</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 watch one of half a dozen television shows like 3 Criminal Minds and The Following and -- well, 4 there's -- you know, and movies by the dozen 5 that portray serial killers in our midst with 6 antisocial personality disorders; correct?</p> <p>7 A. The term is used in that context.</p> <p>8 Q. Okay. And if I remember your CV 9 correctly, you have been more than occasionally 10 called on by the media to talk about serial 11 killers like the BTK killer?</p> <p>12 A. Right.</p> <p>13 Q. And so you're quite aware of the 14 connotation of antisocial personality disorder 15 on people in common parlance here in the United 16 States; correct?</p> <p>17 A. It's probably used in common 18 parlance, but it has, I think, within the 19 general population, a negative or pejorative 20 connotation.</p> <p>21 Q. And, actually, it's actually misused 22 in this report in terms of to the extent it 23 implied that you forensically didn't endorse 24 the diagnosis; correct?</p> <p>25 A. It is misused in my report. This</p>
<p style="text-align: right;">Page 39</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 before age 15 is not well documented, so that's 3 an open issue.</p> <p>4 I don't believe you can say that the 5 antisocial behavior occurred outside the 6 spectrum of the psychotic disorder, so I don't 7 think that can be stated within a reasonable 8 degree of medical certainty.</p> <p>9 Q. In fact, it would be fair to state 10 that the antisocial personality disorder 11 mentioned is really from one -- spins out of 12 one source. It was not a physician; correct?</p> <p>13 A. The term antisocial personality 14 disorder is rendered by a nonphysician and 15 present to my review in the record only a 16 single time. There are aspects of antisocial 17 personality disorder which are in the record 18 separate and apart from that, but I think the 19 overall criteria cannot be met for the reasons 20 I just discussed.</p> <p>21 Q. We'll go on to that in a little bit. 22 Antisocial personality disorder has this huge 23 negative connotation these days, doesn't it?</p> <p>24 A. And probably always has. But yes.</p> <p>25 Q. Well, you know, you only have to</p>	<p style="text-align: right;">Page 41</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 was a reflection of records that I reviewed and 3 was also based on information in the report 4 that could be consistent with antisocial 5 personality disorder.</p> <p>6 So I don't think the term misused is 7 appropriate. I think it is reasonable to say 8 that this would be the sole diagnostic 9 condition mentioned on this page which could be 10 reasonably disputed.</p> <p>11 Q. Well, there isn't enough record 12 evidence to support a forensic diagnosis under 13 DSM-IV-TR for antisocial personality behavior 14 on the part of David Cornelius Smith; correct?</p> <p>15 A. There is not enough information 16 regarding his adjustment and life prior to age 17 15, and there is not enough information to 18 state that the antisocial behavior did not 19 occur exclusively during the course of a 20 psychotic disorder. So with that said, yes, 21 you're correct.</p> <p>22 Q. Schizoaffective disorder, is that an 23 Axis I diagnosis?</p> <p>24 A. Yes, sir.</p> <p>25 Q. Antisocial personality disorder is</p>

<p style="text-align: right;">Page 42</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 an Axis II diagnosis; correct? 3 A. Correct. 4 Q. And the essential feature of 5 antisocial personality disorder is a pervasive 6 pattern of disregard for and violation of the 7 rights of others that begins in childhood or 8 early adolescence and continues into adulthood; 9 correct? 10 A. Correct. 11 Q. This pattern is also referred to as 12 psychopathy, sociopathy, dyssocial personality 13 disorder, as well? 14 A. Yes. 15 Q. Were you aware that depositions had 16 been taken by the defense counsel of his mother 17 and siblings, the people who lived with him in 18 Peoria? 19 A. I think I was aware that that was 20 going to be done, but I didn't know it had been 21 done. 22 Q. And, certainly, questions about that 23 and evidence about his early -- his adolescence 24 and childhood could have been asked at that 25 time?</p>	<p style="text-align: right;">Page 44</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 Q. And we know he used dextromethorphan 3 the 1st of September; correct? 4 A. Correct. 5 Q. And we don't know if he used it any 6 time in between? 7 A. That would be correct. 8 Q. Okay. And, again, then you say that 9 in describing dextromethorphan that it has 10 known, quote, "PCP/phencyclidine-like," and 11 there's no end to the -- where is the end of 12 the quote supposed to be? 13 A. Well, PCP is the acronym, and slash 14 phencyclidine is the chemical name. 15 Q. Sure. 16 A. And so the dextromethorphan, since 17 it's not PCP, would have phencyclidine-like 18 intoxicants and psychotomimetic properties. 19 Q. Well, it's a different body of 20 chemicals -- right -- a different kind of 21 chemicals? 22 A. They have different chemical 23 structures, but they are both dissociative 24 amnestic with psychotomimetic properties. 25 Q. Again, PCP is one of those words</p>
<p style="text-align: right;">Page 43</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 A. Anything could have been asked of 3 them. Well, not anything, but many things 4 could have been asked of them which might have 5 included that. 6 Q. Sure. They were people around him 7 when he was a child. 8 A. Yes. 9 Q. You also, in this report, say things 10 like Mr. Smith was a regular abuser of 11 over-the-counter cough medicine containing 12 dextromethorphan, and I want to focus on some 13 of the word choices. Regular means what in a 14 forensic psychiatric setting? Once a year? 15 Once a month? Once a week? 16 A. In an ongoing fashion. I think once 17 a year would be stretching it. In an ongoing 18 fashion, which might be anywhere from monthly 19 to daily, hourly. Well, daily. Let's leave it 20 at that. 21 Q. Well, for example, we know that he 22 used dextromethorphan on the 9th of September. 23 A. Correct. 24 MR. OSBORNE: I think that's 25 right.</p>	<p style="text-align: right;">Page 45</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 like antisocial personality disorder that has a 3 negative, pejorative connotation; correct? 4 A. But in this particular instance the 5 characterization of dextromethorphan as having 6 similar clinical properties when used as an 7 intoxicant to PCP is legitimate. So while I 8 guess there could be pejorative qualities, the 9 characterization is legitimate. 10 Q. Then you go on to say 11 dextromethorphan intoxication and other forms 12 of substance abuse and dependence were a 13 regular feature of Mr. Smith's day-to-day. I 14 don't know, again, what regular feature means. 15 A. Can you just point me to where you 16 are, sir. 17 Q. It's the sentence that starts on the 18 bottom of Page 1. 19 A. Okay, thank you. 20 Q. And goes over. 21 A. Okay. What is your question? 22 Q. Well, what is regular feature? You 23 used this regular -- or do you mean to express 24 a medical -- does it have a medical meaning, 25 regular, like you would -- a bowel movement</p>

<p style="text-align: right;">Page 46</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 would be regular every day? What are you -- 3 you know. 4 A. In this particular instance the use 5 of the word regular reflects the fact that 6 Mr. Smith had multiple references in the record 7 to substance abuse as a defining feature of his 8 clinical situation and that he had been in 9 multiple venues specifically for treatment of 10 substance abuse-related problems. 11 So the term regular as I used it in 12 this sentence would refer to the fact that this 13 was not an episodic problem but was an ongoing 14 and clinically significant problem. 15 Q. Schizoaffective disorder is, as I 16 understand it, and according to Dr. Zimmerman, 17 schizoaffective disorder is people that have a 18 prominent depression or mania along with the 19 psychosis, and people with straight 20 schizophrenia do not; correct? 21 A. Right. There is an affective or 22 mood component with the psychotic disorder. 23 Q. And Dr. Zimmerman describes David's 24 existence as having periods of sobriety, what 25 you call -- and high functioning, good David,</p>	<p style="text-align: right;">Page 48</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 David and bad David. And sometimes David would 3 be able to get prescription medications that 4 would deal with the lower functioning end and 5 bring it back into sobriety, and sometimes he 6 would take -- he would self-medicate. 7 And that whole pattern is 8 reasonably typical for people with 9 schizoaffective disorder who have prominent 10 depression as their defining schizoaffective 11 nature. 12 A. That's a broad summation of the 13 record. The record is voluminous, spans a 14 great deal of time. And I believe the tenor of 15 Mr. Smith's disorders changed such that over 16 time he appeared to have been less functional, 17 and the substance abuse disorders appeared to 18 have had an autonomous nature. 19 So with that caveat that I don't 20 necessarily endorse the characterization of the 21 record as you've related the testimony of 22 Dr. Zimmerman, it is true that individuals with 23 any number of psychiatric disorders may, in 24 part or in whole, use substance abuse as a form 25 of self-medication as a general precept, that's</p>
<p style="text-align: right;">Page 47</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 and then periods when he was depressed, and 3 depending or not whether he could get 4 regular -- or whether prescription medicine or 5 this self-medication, it would be the band-aid, 6 it would be a different cycle. That's often 7 the case with people with schizoaffective 8 disorder; correct? 9 A. Can I ask you to read the question 10 back to me, please? 11 Q. I can maybe try to make it better. 12 A. If you could. 13 Q. I get it. It wasn't a great 14 question. 15 A. Well -- 16 Q. People with schizoaffective disorder 17 are not necessarily depressed all of the time; 18 correct? 19 A. They would have discrete affective 20 episodes, correct. 21 Q. David's history, according to his 22 treating psychiatrist, was evidenced by periods 23 of sobriety and good functioning, higher 24 functioning, and then periods of nonsobriety 25 with lower functioning, what he called good</p>	<p style="text-align: right;">Page 49</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 correct. 3 Q. Well, Dr. Zimmerman testified, 4 quote, "He did fairly well as long as he was 5 taking his medications and sober." 6 A. That's a tautology, but okay. I'm 7 sorry to interrupt you. 8 Q. I'm just telling you what he said. 9 A. Yes, sir. 10 Q. In fact, I can show it to you, if 11 you'd like. He did have trouble maintaining, 12 sobriety over a long period of time; correct? 13 A. Yes, sir. 14 Q. And you are not a pharmacologist, 15 are you? 16 A. Sure. I treat patients with 17 medication every day. 18 Q. You've not taken any -- you're not 19 Board certified in pharmacology? 20 A. No. But every psychiatrist in this 21 country who is a graduate of an American 22 training program has extensive training in 23 pharmacology. That's the backbone of 24 psychiatric treatment circa 2013. 25 Q. Going back to the things you</p>

<p style="text-align: right;">Page 50</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 reviewed, did you get any of the deposition 3 exhibits? I don't see that on your -- 4 A. May have, if they were attached to 5 the deposition transcript. I'd have to look. 6 Q. Okay. You don't know? 7 A. I have not committed the record to 8 memory in the sense of knowing and seeing in my 9 mind's eye every page, so it's possible that 10 there are exhibits appended to various 11 depositions. 12 Q. Who is kind of the person, the guy, 13 the man, as it were, in dextromethorphan 14 research these days? 15 A. That I don't know. 16 Q. Barry Logan? 17 A. Not a name familiar to me. 18 Q. Do you ever use a laboratory called 19 NMS? 20 A. Yes. 21 Q. They're in Willow Grove, 22 Pennsylvania? 23 A. I didn't know that, but I have used 24 NMS. They're a common national chain of 25 laboratories.</p>	<p style="text-align: right;">Page 52</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 publications, and it's certainly my experience 3 as somebody who regularly treats substance 4 abusers. 5 Q. What research are you specifically 6 relying on? 7 A. I think the PDR or any other such 8 similar research. 9 Q. The PDR doesn't say it has 10 phencyclidine-like -- 11 A. Give me one second. I brought some 12 articles which are on point, but there are 13 many, many such articles in the literature. 14 Q. Well, which ones? 15 A. I brought a Drug and Human 16 Performance Fact Sheet from the NHTSA.gov 17 website. I'm going to forget what that acronym 18 means, and I apologize for that. I brought an 19 article entitled Massive Dextromethorphan 20 Ingestion and Abuse. 21 Q. Who is that by? 22 A. Well, let's see here. That is by 23 Timothy Wolfe, M.D. and a Dr. Caravati, 24 C-A-R-A-V-A-T-I, M.D., from the Division of 25 Emergency Medicine, University of Utah School</p>
<p style="text-align: right;">Page 51</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 Q. Well, did you read Deposition 3 Exhibit No. 19? 4 A. And that would be which one? 5 MR. OSBORNE: Which deposition 6 is that, Bob? 7 MR. BENNETT: Let's go off the 8 record for a bit. I need to use the men's 9 room, anyway. 10 THE VIDEOGRAPHER: Going off 11 the record at 9:46 a.m. 12 (Off the record.) 13 THE VIDEOGRAPHER: We're back 14 on the record at 9:50 a.m. 15 BY MR. BENNETT: 16 Q. Going back to your statement that 17 dextromethorphan is a substance with a known 18 PCP/phencyclidine-like intoxicant and psycho -- 19 how do you say that? 20 A. Psychotomimetic. 21 Q. Psychotomimetic properties, on what 22 do you rely for that statement? What 23 research -- 24 A. I believe that's reflected in a 25 number of different research and clinical</p>	<p style="text-align: right;">Page 53</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 of Medicine. 3 Q. Is that a peer-reviewed article? 4 A. I believe it is. And I have brought 5 an article entitled Severe Manifestations of 6 Coricidin Intoxication, authored by a Thomas 7 K-I-R-A-G-E-S and others from Cook County 8 Hospital. I believe this is a peer-reviewed. 9 Q. May I see that? 10 A. Sure. Do you want them all? 11 Q. Sure. 12 A. But there are others out there. 13 MR. BENNETT: Let's go off the 14 record for a second. I want to take a quick 15 look at this. 16 THE VIDEOGRAPHER: Going off 17 the record at 9:54 a.m. 18 (Off the record.) 19 THE VIDEOGRAPHER: We're back 20 on the record at 9:58 a.m. 21 BY MR. BENNETT: 22 Q. I've had a chance to review, and I 23 thank you for that chance, Doctor, the three 24 articles that you mentioned. The first is a 25 Drug and Human Performance Fact Sheet at</p>

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<p>1 Dr. Bernstein - by Mr. Bennett 2 www.NHTSA.gov on dextromethorphan; correct? 3 A. Yes, sir. 4 Q. And I've reviewed that article. I 5 can't find any mention of phencyclidine or PCP. 6 Can you? 7 A. Those terms may not be in the 8 article, but I think the description of the 9 effects of the agent would be consistent with 10 phencyclidine and/or PCP. And I believe there 11 are, in the literature, references to PCP-like 12 properties of dextromethorphan, but that term 13 in and of itself may not be contained within 14 this document.</p> <p>15 Q. So the simple answer to my question 16 about whether or not PCP was mentioned or 17 phencyclidine was mentioned is no; correct? 18 A. Referencing my prior answer without 19 repeating it, that's correct.</p> <p>20 Q. The other article, Massive 21 Dextromethorphan Injection -- 22 A. Ingestion. 23 Q. -- Ingestion and Abuse from the 24 American Journal of Emergency Medicine, 25 actually the words phencyclidine and PCP</p>	<p>1 Dr. Bernstein - by Mr. Bennett 2 that in human beings that dextromethorphan 3 causes -- has PCP or phencyclidine-like 4 intoxicants and psychotomimetic properties; 5 correct? 6 A. That sentence is not contained 7 within this article. 8 Q. And it doesn't really stand for that 9 scientific proposition, does it? 10 A. The article? 11 Q. Yes. 12 A. I think the article speaks to an 13 individual who was abusing Robitussin and 14 presented with a number of symptoms, including 15 psychotic symptoms. So I would say that it 16 does stand for that. 17 Q. All right. It doesn't say it, 18 though, does it? 19 A. I think a reading of the article 20 would be consistent with that conclusion. The 21 exact sentence as you've promulgated it in your 22 prior question is not contained within the 23 article. 24 Q. And the other, the third article, 25 Severe Manifestations of Coricidin</p>
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<p>1 Dr. Bernstein - by Mr. Bennett 2 appear, but it says they were not evaluated on 3 Page 2. And on Page 3 they say that, I quote, 4 "Experimental evidence in animal models 5 suggests that the physical effects of DM and 6 its abuse potential are caused by the active 7 metabolite dextro" -- say that for me, please. 8 A. Where is it? Dextrophan. 9 Dextrophan. I'm sorry. 10 Q. -- "dextrophan. And this 11 metabolite binds the same CNS receptors as PCP, 12 and animals exhibit similar activity if given 13 either drug. The level of Dextrophan 14 metabolite is highly variable," and it says, 15 "Five to ten Caucasians lack the enzyme to make 16 it." Correct? That's what it says? 17 A. Excuse me one second, please. 18 Quote, "This metabolite binds the same CNS 19 receptors as PCP, and animals exhibit similar 20 activity if given either drug. The level of 21 dextrophan metabolite is highly variable; five 22 to ten Caucasians lack the enzyme to make it, 23 whereas in others there is extensive 24 metabolism," close quote. 25 Q. Nowhere in this article does it say</p>	<p>1 Dr. Bernstein - by Mr. Bennett 2 Intoxication, doesn't mention PCP or 3 phencyclidine at all; correct? 4 A. I believe you are correct. 5 Q. Let me see that again. And that 6 case involves two cases, both 16-year-old 7 girls; correct? 8 A. I believe that's correct. 9 Q. And one ingested 20 tablets of 10 Coricidin HBP Cough & Cold and some other 11 drugs. The other one ingested 50 tablets of a 12 different Coricidin preparation and Coricidin 13 HBP Maximum Strength Flu; is that correct? 14 A. Yes. 15 Q. Both girls lived? 16 A. I believe that's correct. 17 Q. And both -- one was discharged to 18 within a few hours, and one was discharged 19 within a week -- correct -- from the hospital? 20 A. Case in point, No. 1, quote, "The 21 patient required 72 hours of inpatient 22 monitoring until her vital signs and mental 23 status returned to normal." 24 Q. 72? 25 A. 72. I'm sorry. She was discharged</p>

<p style="text-align: right;">Page 58</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 to home. The second individual after a 3 seven-day hospital stay, the patient was 4 discharged.</p> <p>5 Q. But that would be consistent with 6 Dr. Baker's testimony that he never heard of 7 anybody dying from a Coricidin overdose?</p> <p>8 A. I think that would be a broad 9 extrapolation of those two case series. I'm 10 not here to opine whether or not 11 dextromethorphan was the cause or contributing 12 factor to this gentleman's death. But to take 13 any one of those articles and then use it to 14 make the statement that you made I believe is 15 overreading of the article.</p> <p>16 Q. That's a regular feature of mine. 17 A. Well, I appreciate that.</p> <p>18 Q. You talk about Mr. Smith having 19 taken cough syrup on your report; is that 20 right?</p> <p>21 A. Excuse me one second. Cough 22 medicine containing dextromethorphan.</p> <p>23 Q. And then cough syrup appears on the 24 next page?</p> <p>25 A. Need to find that. Where are you on</p>	<p style="text-align: right;">Page 60</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 without repeating it, I think it is the 3 condition most open to debate, and even 4 deleting it does not substantively change my 5 opinion.</p> <p>6 Q. Okay. And then you say, "He had 7 regular contact with police, due to his public 8 intoxication" --</p> <p>9 A. Right.</p> <p>10 Q. -- "and symptoms from his untreated 11 psychiatric and substance abuse problem." 12 Again, what's regular contact? Once a month? 13 Once a week? Once a year?</p> <p>14 A. I did not go through the record and 15 codify or add that up, but it appears that in 16 many instances the police were involved in 17 situations that involved him.</p> <p>18 Q. How many?</p> <p>19 A. I didn't add it up. If you'd like, 20 we can take a break, and I can do that.</p> <p>21 Q. Well, are you aware of any arrests 22 or convictions?</p> <p>23 A. According to the discovery materials 24 that I received, I believe there was a 25 disorderly conduct arrest and I'm assuming</p>
<p style="text-align: right;">Page 59</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 the page?</p> <p>3 Q. Answer to Question 2.</p> <p>4 A. Okay. Give me one second. You are 5 correct, the term cough syrup is there. 6 Actually, the sentence reads "Severely" -- in 7 part, "Severely intoxicated on dextromethorphan 8 and other constituents of cough syrup, as 9 opposed to" --</p> <p>10 Q. Do you have any evidence that he 11 took cough syrup at all?</p> <p>12 A. No. And the sentence wasn't 13 proffered as such. I believe the chemicals, 14 the substances in both preparations would be 15 similar, if not identical.</p> <p>16 Q. Okay. Your report goes on, Page 2, 17 says, "As a result of his schizoaffective 18 disorder, antisocial personality disorder, 19 substance abuse, and treatment noncompliance, 20 Mr. Smith was frequently homeless and/or 21 intoxicated." Do you see that?</p> <p>22 A. Yes, sir.</p> <p>23 Q. And now you don't really want to say 24 antisocial personality disorder there, do you?</p> <p>25 A. Referencing my prior testimony</p>	<p style="text-align: right;">Page 61</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 conviction and an intoxication-related arrest, 3 I believe, although I'd have to look, and that 4 was in the discovery materials that I saw.</p> <p>5 Q. You say the week prior to 9/9/2010, 6 Mr. Smith had been emergently treated for 7 dextromethorphan intoxication, and that was at 8 HCMC?</p> <p>9 A. Hennepin County?</p> <p>10 Q. Hennepin County Medical Center.</p> <p>11 A. Yes, sir.</p> <p>12 Q. And he was released the same night; 13 correct?</p> <p>14 A. I believe that's correct.</p> <p>15 Q. Alive?</p> <p>16 A. Yes, alive.</p> <p>17 Q. And you have read the -- did you 18 read the Exhibit 9? Have you seen that?</p> <p>19 A. I've seen this before.</p> <p>20 Q. All right. So this is from the NMS 21 lab in Willow Grove, Pennsylvania; correct?</p> <p>22 A. Yes.</p> <p>23 Q. And that's a well known and regarded 24 lab; is that correct?</p> <p>25 A. It's a very common national</p>

<p style="text-align: right;">Page 62</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 laboratory. If I received results from them, I 3 would not have cause to question the results. 4 What their reputation might be beyond that, I 5 don't know.</p> <p>6 Q. They found two substances that were 7 abnormal; correct?</p> <p>8 A. Yes, sir.</p> <p>9 Q. One was chlorpheniramine, and the 10 other was dextro or levomethorphan?</p> <p>11 A. Yes.</p> <p>12 Q. And on Page 2 they describe what 13 they call reference comments. Do you see that?</p> <p>14 A. I do.</p> <p>15 Q. Reference comments describe the drug 16 and its effects -- correct -- of 17 chlorpheniramine or dextro or levomethorphan?</p> <p>18 A. I'm sorry. Could you read the 19 question back to me, please.</p> <p>20 Q. The reference comments there, you 21 see chlorpheniramine and dextro and 22 levomethorphan are on Page 2; correct?</p> <p>23 A. I see that.</p> <p>24 Q. And they describe the drug and its 25 effects?</p>	<p style="text-align: right;">Page 64</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 low as 3300 NG over ML in blood. How would you 3 say that?</p> <p>4 A. Nanograms per milliliter.</p> <p>5 Q. In blood; is that right?</p> <p>6 A. You read that correctly.</p> <p>7 Q. And they measured the dextro or 8 levomethorphan at 2,000; correct?</p> <p>9 A. Yes, sir.</p> <p>10 Q. Is central nervous system depression 11 consistent with increased or elevated strength?</p> <p>12 A. Generically speaking, when somebody 13 is undergoing central nervous system 14 depression, then they would be lethargic as 15 opposed to agitated, as a generic precept.</p> <p>16 Q. How about dizziness? Would that be 17 consistent with elevated or increased strength?</p> <p>18 A. It might or might not.</p> <p>19 Q. How about ataxia?</p> <p>20 A. Same answer.</p> <p>21 Q. Have you found people who are ataxic 22 to have elevated strength, ever?</p> <p>23 A. Sure. If you ever worked in an 24 emergency room, I mean, somebody who is 25 substantially intoxicated can hurt you and can</p>
<p style="text-align: right;">Page 63</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 A. Amongst other things is a brief 3 rendition of the effects the drug may have at a 4 toxic level.</p> <p>5 Q. And there's no indication there that 6 there is any PCP or phencyclidine-like 7 properties or effects in the NMS laboratory 8 reference comments -- correct -- for dextro or 9 levomethorphan?</p> <p>10 A. Hallucinations would be a PCP-like 11 effect, but the term PCP or phencyclidine or 12 PCP-like is not contained within the document.</p> <p>13 Q. And they also -- it goes on to state 14 that "Overdose of DM is rare. Overtotoxicity, 15 which may include death, is usually manifested 16 when doses exceed 100 times the normal adult 17 dose." They say that; correct?</p> <p>18 A. You read that correctly.</p> <p>19 Q. They also say that "The observed 20 symptoms include central nervous system 21 depression, hallucination, dizziness, and 22 ataxia"; correct?</p> <p>23 A. You read that correctly.</p> <p>24 Q. And the fatalities have been 25 reported to dextromethorphan concentrations as</p>	<p style="text-align: right;">Page 65</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 engage gauge in feats of strength which would 3 be startling, given their body habitus or age 4 or level of debilitation.</p> <p>5 Q. They also tested for a number of 6 other drugs in Exhibit 15; correct?</p> <p>7 A. Excuse me one second. Yes, sir.</p> <p>8 Q. They tested for amphetamines?</p> <p>9 A. Correct.</p> <p>10 Q. That was negative?</p> <p>11 A. Yes.</p> <p>12 Q. Barbiturates was negative?</p> <p>13 A. Yes, sir.</p> <p>14 Q. Benzodiazapine was negative?</p> <p>15 A. Yes.</p> <p>16 Q. Cocaine metabolites was negative?</p> <p>17 A. Correct.</p> <p>18 Q. LSD negative?</p> <p>19 A. Yes, sir.</p> <p>20 Q. Methadone negative?</p> <p>21 A. Correct.</p> <p>22 Q. The opiate urine -- 23 dextromethorphan, would that test for that?</p> <p>24 That's an opiate-like substance, they say?</p> <p>25 A. You can get a false positive at the</p>

<p style="text-align: right;">Page 66</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 radioimmunoassay level, but it would not 3 confirm it at the mass spectroscopy level. 4 Q. They did test for phencyclidine and 5 PCP; correct? 6 A. Yes, sir. 7 Q. And that was negative? 8 A. Correct. 9 Q. The other two drugs there were 10 negative, as well; correct? 11 A. One was aspirin, and the other is a 12 weak sedative called propoxyphene, but they 13 were both negative. 14 Q. Okay. 15 A. Just to amend my answer, it says 16 underneath there chromatography urine, which 17 would be a confirmatory test, and it says 18 specimen quantity not sufficient for 19 chromatography. So it is possible the 20 individual had opiates in his urine, but it is 21 also possible that's a false positive from the 22 dextromethorphan. 23 We'll never know, because there 24 simply wasn't enough specimen to do the 25 confirmatory test.</p>	<p style="text-align: right;">Page 68</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 expectancy of 50 years for Mr. Smith? 3 A. Right. I think for an individual 4 who passes out on train tracks, that's not an 5 unreasonable estimate and may, in fact, be 6 generous. 7 Q. Well, I know, but really, and the 8 only article you cite is this <i>Opening Eyes</i>, 9 <i>Opening Minds: The Ontario Burden of Mental</i> 10 <i>Illness and Addictions Report</i>; correct? 11 A. Correct, that is the only one that I 12 cite. There are other articles available. 13 Q. What are they? 14 A. Let's think. MMWR, the morbidity 15 and mortality weekly report published by the 16 CDC I believe has articles on point in that 17 regard. 18 Q. Well, none of them allow you to pick 19 specific days, do they? 20 A. No. I mean, at a certain point you 21 have to apply your own acumen. The gentleman 22 had a long list of risk factors associated with 23 a less than actuary predicted lifespan. 24 MR. BENNETT: Can you mark 25 this exhibit, please.</p>
<p style="text-align: right;">Page 67</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 Q. What specific PCP-like properties or 3 effects are you talking about? 4 A. Agitation, hallucinations, violence. 5 I think that covers it. 6 Q. Well, those things could be 7 associated with other things, including his 8 psychosis; correct? 9 A. Yes, that's a possibility, or it 10 could be a product of the two, synergistic 11 effect. 12 Q. Now, you were asked the first 13 question, what was the expected lifespan, so 14 even if you look at all 105 of the areas of 15 your expertise, lifespan wasn't listed, was it? 16 A. I don't believe the term lifespan is 17 in that list. 18 Q. Or anything that would lead us to 19 believe that that is an area of your expertise? 20 A. Well, if one treats patients with 21 any degree of regularity as a physician, you're 22 certainly aware of factors which would decrease 23 or truncate an individual's lifespan, but I'm 24 not an actuarial expert. 25 Q. Well, you did predict a life</p>	<p style="text-align: right;">Page 69</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 (Deposition Exhibit No. 6 was 3 marked for identification.) 4 Q. This article that you said is not a 5 peer-reviewed article, is it? 6 A. It's the product of the public 7 health entity for Ontario. 8 Q. I know that. But -- 9 A. I wasn't complete with my answer. 10 Q. Okay. 11 A. So, as such, I'm sure there's some 12 type of internal peer review process, but it 13 was not published in a peer-reviewed journal. 14 Q. We are not in Canada, are we? 15 A. We're not far from it. And the 16 issues addressed here are generic for western 17 countries with individuals with psychiatric 18 disease and substance abuse. 19 In fact, their numbers may be a 20 little bit better, because they do a better job 21 of taking care of their mentally ill through 22 their public health system. Let me amend that 23 answer. They have more readily accessible 24 services than we do in this country because of 25 the nature of their public health system.</p>

<p style="text-align: right;">Page 70</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 Q. Well, are you telling me that you 3 hold the opinion to a reasonable degree of 4 medical certainty that the most he would ever 5 live to was 50 years? 6 A. That would require clairvoyance. I 7 think the likelihood of his living to 50 years 8 was extremely low, given the factors that I've 9 described. But I can't say that he wouldn't 10 have. I can't say that he wouldn't have lived 11 to 150 years. I just don't know. 12 Q. So that opinion you're not 13 expressing to a reasonable degree of medical 14 certainty? 15 A. Which opinion? 16 Q. "I believe that Mr. Smith's mix of 17 severe mental disorders, regular substance 18 abuse, medical history, legal history, frequent 19 homelessness, and treatment noncompliance 20 predict, at best, a life expectancy of 50 21 years." 22 A. Utilizing the definition of 23 reasonable degree of medical certainty as more 24 likely than not, I stand by that statement. 25 Q. The foundation for that is what you</p>	<p style="text-align: right;">Page 72</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 indicating the usage at that level promotes 3 psychotomimetic effects? 4 A. Not per se, but individuals' 5 reaction to this type of substance can be 6 idiosyncratic. Therefore, I don't think you 7 can reliably state that there is a 8 dose-response effect at which any given level 9 will -- a majority of individuals produce a 10 given set of findings. 11 So I'm not aware of any such 12 literature, and for the reasons I've just 13 stated, I don't believe that such literature is 14 a foundation for my opinion. 15 Q. Do you know what kind of metabolizer 16 David Smith was? 17 A. In terms of dextromethorphan? 18 Q. Yes. 19 A. No, I do not. Obviously, he's -- 20 well, they measured the parent compound and not 21 the metabolite. No. I cannot say if he is a 22 fast or slow metabolizer or an individual who 23 lacks the enzyme. 24 Q. In terms of the lifespan, what facts 25 are you relying on to provide that opinion?</p>
<p style="text-align: right;">Page 71</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 say? 3 A. The multiplicity of risk factors 4 that would be discussed and my own clinical 5 acumen. 6 Q. Let's go back to the PCP-like 7 intoxicants. Are the properties that you're 8 talking about, the similarities between 9 dextromethorphan and PCP-like properties, are 10 they shared by other types of substances? 11 A. Other agents that have similar 12 properties. One that comes to mind would be 13 ketamine, K-E-T-A-M-I-N-E. Are there other 14 substances with similar clinical properties. 15 There are more likely than not or anesthetic 16 agents, but I can't think of them off the top 17 of my head. What about medications one might 18 have as an outpatient or over-the-counter? 19 Q. Your understanding of Mr. Smith's 20 documented level of dextromethorphan was 200 21 nanograms per milliliter? 22 A. 2,000. 23 Q. 2,000? 24 A. Yes, sir. 25 Q. Are you aware of any literature</p>	<p style="text-align: right;">Page 73</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 A. Engaging in dangerous behaviors such 3 as passing out on railroad tracks; substance 4 abuse to include intoxication and overdose; the 5 contracting of sexually transmitted diseases 6 and, therefore, being at risk for other such 7 diseases which could decrease his lifespan. 8 Q. Can I interrupt you there for just a 9 moment? 10 A. Sure. 11 Q. What sexually transmitted diseases 12 do you think he had? 13 A. I believe he was treated for 14 chlamydia, and I don't remember the other 15 agent, the other organism. 16 Q. What besides this Ontario article, 17 Exhibit 6, are you relying on to provide this 18 opinion? 19 A. Well, there are other articles in 20 the literature which I can get, if you want me 21 to, and my own -- 22 Q. I'm talking about ones you've read 23 or relied upon for this opinion. 24 A. There are various MMWR articles 25 which I did not bring with me, and my own</p>

<p style="text-align: right;">Page 74</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 experience and training. 3 Q. You didn't reference any in the 4 MMWR? 5 A. I did not. 6 Q. Did you have any specific data 7 comparing or contrasting the treatment the 8 mentally ill receive in Ontario compared to 9 Minnesota or elsewhere in the United States? 10 A. No, I did not. 11 Q. What tools are you using to get to a 12 life expectancy of 50 years? 13 A. My clinical acumen in treating 14 patients similar to this. 15 Q. What are you using as a baseline for 16 average black male life expectancy? 17 A. For his age cohort it would be in 18 the seventies. 19 Q. Did Mr. Smith have any systemic 20 disease that you know of? 21 A. I am not aware of his having any 22 systemic disease. 23 Q. And how many people do you treat 24 with schizophrenia or schizoaffective disorder? 25 A. At this juncture I'd say more than</p>	<p style="text-align: right;">Page 76</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 issue of his impulsive aggressive behavior a 3 medication in the class of the anti-convulsant 4 medication Trileptal? 5 A. Trileptal, right. 6 Q. Would have been -- may have been 7 helpful in dealing with that? 8 A. Well, it gets dicey, because 9 Mr. Smith, amongst other agents, was an abuser 10 of alcohol, and there may be some synergy in 11 terms of liver damage with Trileptal. But, 12 yes, that is something you could have used. 13 Q. There wasn't any liver damage noted 14 in the autopsy; correct? 15 A. I'll have to look, which I think I 16 have here. The liver was not sectioned, so to 17 the external inspection, it was noted to be 18 congested. Well, no, I guess it was -- it did 19 undergo microscopic. My mistake. So that is 20 correct, there is no evidence at autopsy of 21 extant liver disease. 22 Q. He didn't have any of a number of 23 the health problems that would specifically 24 impact mortality like hypertension or diabetes; 25 correct?</p>
<p style="text-align: right;">Page 75</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 50, less than a hundred. 3 Q. And are you aware of the medications 4 that Dr. Schulz talks about in terms of 5 promoting a better outcome and longer term 6 sobriety and longer term good days? 7 A. I'm aware, I believe he discusses 8 Clozaril, and I believe he mentions depot or 9 long-acting antipsychotics. I'm aware of 10 those. 11 Q. Haloperidol decanoate? 12 A. Yes, sir. Decanoate. I thought you 13 said is haloperidol a candidate. I'm sorry. 14 Yes, decanoate. 15 Q. And Risperdal? 16 A. Correct. 17 Q. Would those have been appropriate 18 choices to assist David in staying on 19 antipsychotic medication? 20 A. Yes. 21 Q. And then he also recommended 22 clozapine? 23 A. Clozaril, yes. That's the brand 24 name. Clozapine is the generic. 25 Q. And he also recommended for the</p>	<p style="text-align: right;">Page 77</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 A. Not yet. He's still a relatively 3 young man. 4 THE WITNESS: Would anyone 5 mind if I adjusted the thermostat? I find it a 6 bit cold in here. Is it troubling anyone else? 7 MR. OSBORNE: None at all. 8 MR. BENNETT: Let's go off the 9 record. 10 THE VIDEOGRAPHER: Going off 11 the record at 10:32 a.m. 12 (Off the record.) 13 THE VIDEOGRAPHER: We're now 14 at the beginning of Tape No. 2 of the 15 deposition of Lawson Bernstein, M.D. The time 16 is 10:49 a.m. 17 MR. BENNETT: Would you want 18 to mark this? 19 (Deposition Exhibit No. 7 was 20 marked for identification.) 21 Q. Have you ever seen that one? 22 A. I have, and then when it was cited 23 in -- 24 Q. By Dr. Schulz? 25 A. Then I read it again, but I had read</p>

<p style="text-align: right;">Page 78</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 it previously. 3 Q. And this actually is a refereed 4 peer-reviewed article; correct? 5 A. That is correct. 6 Q. And it does concede the medical 7 morbidity and mortality rates remain elevated 8 in schizophrenia patients compared with the 9 general population; correct? 10 A. Correct. 11 Q. It says that's in part due to 12 potentially reversible medical risk factors; is 13 that correct? 14 A. Excuse me one second. Yes. 15 Q. And the risk factors they talked 16 about were, for example, cigarette smoking, 17 obesity, diabetes, hypertriglyceridemia, that 18 sort of thing; correct? 19 A. Right. 20 Q. And then HIV and infectious 21 hepatitis were the two others that were 22 mentioned? 23 A. Correct. 24 Q. As far as we know, David didn't have 25 any of those, did he?</p>	<p style="text-align: right;">Page 80</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 Q. Well, there are -- let's look at 3 Exhibit 8 here. 4 (Deposition Exhibit No. 8 was 5 marked for identification.) 6 Q. Are you familiar with this article? 7 A. I'm just trying to find the journal. 8 This is from an entity entitled Medical Care. 9 That's the name of the journal? 10 Q. Yes. 11 A. I must say this is not something 12 that I read on a regular basis. 13 Q. It does say it's -- the article is 14 Understanding Excess Mortality in Persons With 15 Mental Illness; correct? 16 A. That's the title. 17 Q. It says 17-year Follow-Up of a 18 Nationally Representative Study, and it's dated 19 June of 2011. 20 A. Correct. 21 Q. And the study used data from the 22 1989 National Health Interview Survey? 23 A. I'll need to read this. 24 Q. Okay. 25 A. Shall we take a break?</p>
<p style="text-align: right;">Page 79</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 A. I was advised, actually, given some 3 of the data in the records about the question 4 of his prostituting himself -- and I by no mean 5 am passing judgment on that. It's simply a 6 reflection of the record. 7 Q. There is no actual evidence that he 8 did, either, was there? 9 A. But knowing what they knew and that 10 he had had some sexually transmitted diseases, 11 I was surprised that he wasn't offered HIV and 12 hepatitis screening. But you are correct. You 13 read this correctly. 14 Q. This article would not support -- 15 given his history, they talk about the medical 16 guidelines. You didn't use this article in 17 coming to your judgment, though; correct? 18 A. No. I mean, I think this sort of 19 states what is now the obvious, which is that 20 patients with schizophrenic disorders are high 21 risk for a variety of adverse disease outcomes 22 and that what can be done prophylactically to 23 decrease those risks. It does not speak to 24 some of the other factors that were unique to 25 Mr. Smith, but it does speak to some.</p>	<p style="text-align: right;">Page 81</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 Q. Sure. 3 A. Thank you. 4 THE VIDEOGRAPHER: Going off 5 the record at 10:54 a.m. 6 (Off the record.) 7 THE VIDEOGRAPHER: We're back 8 on the record at 10:58 a.m. 9 BY MR. BENNETT: 10 Q. This article is by three people from 11 the Rollins School of Public Health at Emory 12 University; a person from the University of 13 Colorado, Denver School of Public Health; and 14 an individual from the School of Social Work at 15 the University of Pennsylvania School of Social 16 Policy and Practice; correct? 17 A. Yes, sir. 18 Q. Supported by a grant from the 19 National Institute of Mental Health? 20 A. Yes. 21 Q. In terms of the results, they say 22 that persons with mental disorders died an 23 average of 8.2 years younger than the rest of 24 the population; correct? 25 A. Without commenting on the</p>

<p style="text-align: right;">Page 82</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 statistical methodology or the particular 3 shortcomings of the study, yes, that's correct. 4 I believe that estimate, by the author's own 5 conclusion in the paper, understates the 6 diminution in lifespan.</p> <p>7 Q. Where does it say it says that? 8 What page?</p> <p>9 A. I'm finding that for you.</p> <p>10 Q. I didn't think they were too 11 self-deprecating, to be perfectly honest with 12 you.</p> <p>13 A. And I'm at a pretty fair 14 disadvantage having just scanned this, but if 15 you'll give me a moment. (Pause.) All right. 16 We can go back on record.</p> <p>17 Q. Okay. I think we're still on the 18 record.</p> <p>19 A. Thank you. This is quoting from 20 Page 603 of the article on the left side of the 21 page, second full paragraph. "Nonetheless, 22 there was still a trend toward a residual 23 effect of mental disorders on mortality even in 24 this adjusted model, suggesting that mental 25 disorders continue to have an impact on</p>	<p style="text-align: right;">Page 84</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 right?</p> <p>3 A. You referred to a number. I asked 4 you where that was. And I haven't had a chance 5 to look at it.</p> <p>6 Q. I'm sorry: "Persons with psychotic 7 disorders had the earliest and highest rates of 8 mortality. The mean age at death was 63.4 9 years for persons with psychotic disorders, 10 66.0 for individuals with affective disorders, 11 64.0 years for persons with substance abuse 12 disorders, and 71.0 years for persons with 13 other disorders, as compared with 74.4 years 14 for individuals without reported mental 15 disorders." Do you see that?</p> <p>16 A. Yes.</p> <p>17 Q. So the average is 8.2 people with 18 all mental disorders, and for psychotic it's 11 19 years -- correct -- according to this study?</p> <p>20 A. You read the section correctly. 21 There are problems with the way the study is 22 done. But without commenting on those, that is 23 what the authors state.</p> <p>24 Q. Okay. They also stated that of the 25 study group only 5.4 percent of the deaths</p>
<p style="text-align: right;">Page 83</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 mortality over and above the variables measured 3 in the study," close quote.</p> <p>4 I think there is also another 5 reference in here somewhere, and again I've 6 just reviewed this, which speaks to that issue, 7 as well, but that's how I read it. It's an 8 underestimation. There are other 9 methodological issues, as well, but we can --</p> <p>10 Q. They did find that trajectories of 11 mortality varied across the mental disorder, 12 depending on what kind you had; right?</p> <p>13 A. Correct.</p> <p>14 Q. They said persons with psychotic 15 disorder, not surprising to you, I guess, had 16 the earliest and highest rates of mortality?</p> <p>17 A. Agreed.</p> <p>18 Q. And the mean age of death was 73.4 19 versus 74.4 in the normal. That's what they 20 had the normal --</p> <p>21 A. Where are you deriving that, sir?</p> <p>22 Q. 601.</p> <p>23 A. Okay.</p> <p>24 Q. And that's because of the severity 25 of the psychosis in terms of mental disorder;</p>	<p style="text-align: right;">Page 85</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 among persons with mental illness were caused 3 by unnatural causes such as suicide, homicide, 4 or accidents, which did not differ 5 statistically from the rate of unnatural 6 deaths, 4.7 among those without mental 7 disorders.</p> <p>8 A. One second.</p> <p>9 Q. That's above the trajectory right 10 there.</p> <p>11 A. Yes, sir. And where is the 5.4 12 reference?</p> <p>13 Q. It's on 601.</p> <p>14 A. Oh, I see it.</p> <p>15 Q. Right the second -- the first full 16 paragraph in the column.</p> <p>17 A. I see that. There is an internal 18 inconsistency in the document regarding the 19 methodologies used and the reporting of that 20 statistic. Without commenting on that, you 21 read the sentence correctly.</p> <p>22 Q. Well, do you think these folks did a 23 bad job? Is that what you're trying to tell 24 me?</p> <p>25 A. No. What I'm saying is that the</p>

<p style="text-align: right;">Page 86</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 paper, like many papers, has its strengths and 3 weaknesses. And we're talking about statistics 4 which I'm assuming will be proffered at a later 5 date and time, and I think it's necessary to 6 point out what the authors point out, that the 7 article likely underestimates the overall 8 morbidity and mortality of this patient 9 population.</p> <p>10 There is no statistical attempt to 11 meld categories such as substance abuse and 12 psychotic disorders, which is the way things 13 present clinically quite often.</p> <p>14 There is a particular statement 15 under mortality measures regarding sensitivity 16 analyses that were calculated excluding 17 suicide, homicide, and accidents, which is -- 18 I'd have to really drill down into the paper to 19 understand how they're deriving this statistic.</p> <p>20 So while you read the sentence 21 correctly, I don't want -- I think it's 22 necessary to point out that there are severe 23 limitations with the study. And that if it is 24 proffered as some sort of holy grail or 25 absolute statement of fact, which it might be</p>	<p style="text-align: right;">Page 88</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 A. I did not use this article. This 3 article, frankly, would await replication, and 4 so it would be improper to use it for that 5 purpose.</p> <p>6 Q. So it's improper to use this 7 article; is that what you're saying?</p> <p>8 A. As a stand-alone, peer-reviewed, 9 without question document, which is accurate 10 and doesn't contain any type of statistical 11 problems which might make the data relatively 12 or absolutely unreliable, yes, I think it would 13 be premature to use this as some sort of 14 template for calculating life expectancies in 15 patients such as David Smith.</p> <p>16 Q. Would it be better than 17 clairvoyance?</p> <p>18 A. Well, I'm not attempting 19 clairvoyance. What I said was -- I'll find the 20 sentence. "I believe that Mr. Smith's mix of 21 severe mental disorders, regular substance 22 abuse, medical history, including treatment for 23 sexually transmitted diseases, legal history, 24 frequent homelessness, and treatment 25 noncompliance predicted, at best, a life</p>
<p style="text-align: right;">Page 87</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 at some point, that that would be problematic.</p> <p>3 Q. Well, it appears to use what I would 4 consider to be the scientific and statistical 5 methodology that's typically used for studies 6 of this type; correct?</p> <p>7 A. There are no studies of this type. 8 This was the first attempt to do this. It was 9 done retrospectively using a questionnaire with 10 yes or no answers, which the authors rightly 11 discuss as being problematic and prone to 12 error.</p> <p>13 So to say that this is 14 representative of the literature of this type 15 is incorrect, because by the author's own 16 admission, this is the first time this type of 17 study has been done, in this particular 18 methodology.</p> <p>19 Q. I notice they didn't pick any 20 particular number for David Cornelius Smith.</p> <p>21 A. I'm not sure they know the 22 gentleman.</p> <p>23 Q. And did you employ anything nearly 24 this scientific for coming up with 50 years, 25 Doctor?</p>	<p style="text-align: right;">Page 89</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 expectancy of 50 years." That's not 3 clairvoyance. These are factors that are 4 extant in the individual's life.</p> <p>5 Q. How does it compare to the Ontario 6 study in terms of methodology?</p> <p>7 A. Those are epidemiological studies, 8 which one then would extrapolate from to the 9 extent that one can.</p> <p>10 Q. Okay. Do you claim to be expert in 11 the prediction of the level of violence of 12 human beings?</p> <p>13 A. Well, the field of psychiatry, 14 through its own resources, has determined that 15 our ability to predict violence is no better 16 than chance. I probably have more than the 17 average level of psychiatric experience with 18 violent individuals and the prediction of 19 violence. So perhaps I'm somewhat better than 20 the average psychiatrist would be. That would 21 be my answer.</p> <p>22 Q. Before the police laid hands on him, 23 what violent act, if any, did David Cornelius 24 Smith do on September 9 of 2010?</p> <p>25 A. On that day?</p>

<p style="text-align: right;">Page 90</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 Q. Yes. 3 A. I am not aware -- I believe he was 4 acting strangely and in a fashion that 5 individuals found frightening and aggressive, 6 so in that context one would consider this a 7 type of violence, although not physical 8 violence. 9 Q. Did you read the testimony of the 10 boy who complained? 11 A. What is his name, sir? 12 Q. William Taylor. 13 A. No. 14 Q. So if David asked him his name, 15 would that be violent? 16 A. Depends on the way he asked it. If 17 he asked it in a fashion that was threatening 18 or aggressive, yes. 19 Q. If he asked him how old he was, 20 would that be violent? 21 A. Same answer. 22 Q. So if he didn't ask him in a 23 threatening way, it wouldn't be violent? 24 A. It depends on his body habitus, the 25 way he's standing. I mean, we've all had the</p>	<p style="text-align: right;">Page 92</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 people? 3 A. I've done -- I've participated in 4 trainings, but not with police officers, no. 5 Q. Never with police officers? 6 A. No, sir. 7 Q. Have you done it with hospital 8 personnel? 9 A. Yes, although it's been a while. 10 Q. I mean about that topic. 11 A. About dealing with violent patients? 12 Q. Yes. 13 A. Yes. 14 Q. And you train them to deescalate and 15 not to immediately lay hands on them; correct? 16 A. Right. They're not law enforcement 17 officers, so there may be different standards 18 applicable there, but for hospital personnel 19 working in a mental health facility, that is 20 preferentially, if possible, the first step. 21 Q. To your knowledge, nobody has 22 reported to you that prior to the police laying 23 hands on David, that David had committed any 24 crime; is that true? 25 A. Right. And I haven't come prepared</p>
<p style="text-align: right;">Page 91</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 experience of walking in a subway car or bus 3 terminal and someone is sitting across the way, 4 and this person isn't necessarily doing 5 anything but presents a threatening persona. 6 So I can't say. 7 Q. Did you watch the YMCA video? 8 A. I saw the officer's pen cam video. 9 Q. But that's after they laid hands on 10 him and deciding whether to taser him or not? 11 A. I believe that's correct. 12 Q. Mentally ill people, people 13 particularly with schizophrenia or psychosis, 14 schizoaffective disorder don't like to have 15 people lay hands on them, do they? 16 A. I don't think anybody likes hands 17 laid on them. 18 Q. They like it less than other people, 19 though? 20 A. Certain of those patients, yes, if 21 there is a paranoid spectrum to their thinking. 22 Q. And there was with David; right? 23 A. Yes. 24 Q. Have you been part of training any 25 police force about how to deal with such</p>	<p style="text-align: right;">Page 93</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 to proffer any testimony about what Mr. Smith 3 did or didn't do or what the police should or 4 shouldn't have done. 5 Q. It's just you were asked to -- I 6 mean, are you giving some opinion to a 7 reasonable degree of medical certainty when you 8 answer the question, too? If so, I'd like to 9 know what it is. 10 A. Sure. Let's take it one sentence at 11 a time. "At the time of the altercation, 12 Mr. Smith was apparently noncompliant with 13 psychotropic medication (as was his habit)." "He 14 was on lamotrigine, was supposed to be on 15 lamotrigine. Confirmatory tests for 16 lamotrigine performed at the receiving hospital 17 did not reveal the presence of that agent. 18 Mr. Smith had a history of being noncompliant. 19 So that's expressed within a reasonable degree 20 of medical certainty. 21 "Severely intoxicated on 22 dextromethorphan and other constituents of 23 cough syrup," I believe the toxicology report 24 would support that. 25 "And more likely than not acutely</p>

<p style="text-align: right;">Page 94</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 psychotic from both of these factors both 3 singly and in the aggregate." This gentleman 4 has a history of a psychotic disorder. 5 Psychotic disorders, when unmedicated, can and 6 will get worse. I think those factors are 7 extant here, and that sentence is expressed 8 within a reasonable degree of medical 9 certainty.</p> <p>10 The next sentence is, "In particular 11 the combination of high dose dextromethorphan," 12 parentheses, "(which as noted above is an 13 intoxicant with PCP-like properties)," close 14 parenthesis, "plus unmedicated psychosis is a 15 potent recipe for bizarre, violent, acting-out 16 behaviors such as those evinced by Mr. Smith." 17 That's a general statement which I believe is 18 reflected in the medical literature regarding 19 both conditions, both singly and together.</p> <p>20 "It is also important to note that 21 individuals intoxicated with Mr. Smith's blood 22 level of dextromethorphan but without an 23 underlying autonomous psychotic disorder can 24 present identically to his presentation at the 25 YMCA on September 9, 2010." That's a general</p>	<p style="text-align: right;">Page 96</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 you look.</p> <p>3 A. Thank you.</p> <p>4 THE VIDEOGRAPHER: Going off 5 the record at 11:20 a.m.</p> <p>6 (Off the record.)</p> <p>7 THE VIDEOGRAPHER: We're back 8 on the record at 11:20 a.m.</p> <p>9 A. I have seen that.</p> <p>10 Q. What?</p> <p>11 A. The YMCA video.</p> <p>12 Q. How do you know?</p> <p>13 A. Because I have it here.</p> <p>14 Q. You didn't list it in your report, 15 did you?</p> <p>16 A. My shortcoming for not listing those 17 videos, you are correct, and you have my 18 apologies for that.</p> <p>19 Q. What do you recall seeing in the 20 video?</p> <p>21 A. I don't recall much about the YMCA 22 video. The pen cam video I recall.</p> <p>23 Q. Do you recall anything about the 24 YMCA video?</p> <p>25 A. Not off the top of my head, no.</p>
<p style="text-align: right;">Page 95</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 statement which I believe is correct.</p> <p>3 Q. Based on what?</p> <p>4 A. I'm sorry. I don't follow you.</p> <p>5 Q. Based on those articles you showed 6 me?</p> <p>7 A. And others. Let's go back. "It is 8 important to note that individuals intoxicated 9 with Mr. Smith's blood level of 10 dextromethorphan but without an underlying 11 autonomous psychotic disorder can present 12 identically." That would be predicated on the 13 case reports that I showed you, and there may 14 be others in the literature, as well. And I 15 believe it's also contained within the fact 16 sheet from the National Highway Transportation 17 and Safety Board, which speaks to 18 hallucinations as a side effect of toxicity, as 19 an effect of toxicity, and people who 20 hallucinate can become violent.</p> <p>21 Q. So you haven't seen the video of his 22 conduct before the police arrived; correct?</p> <p>23 A. Excuse me one second. Take this 24 off.</p> <p>25 Q. Why don't we go off the record while</p>	<p style="text-align: right;">Page 97</p> <p>1 Dr. Bernstein - by Mr. Bennett</p> <p>2 Q. We have a video of his conduct 3 before the police arrived and of his initial 4 conduct with the defendant officers. We've 5 established that; right?</p> <p>6 A. Yes, sir.</p> <p>7 Q. So why is it necessary to engage in 8 speculation about whether he was likely or 9 unlikely to be violent or anything else that 10 occurred?</p> <p>11 A. The question was posed to me.</p> <p>12 Q. You don't make any mention in the 13 report about -- in the text of your report 14 about the YMCA video or the taser video, do 15 you?</p> <p>16 A. Let's see if there is reference 17 to --</p> <p>18 Q. Or even the pen camera video?</p> <p>19 A. I know I don't have the taser video. 20 Correct.</p> <p>21 Q. The taser shows him making one 22 offensive strike. He swung and hit Callahan 23 one time; right? It doesn't show any of the 24 blows that he struck; is that true?</p> <p>25 A. I have not seen the taser video.</p>

<p style="text-align: right;">Page 98</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 Q. Well, I mean, on the pen camera 3 video, it only shows one strike; correct? 4 A. Correct. Well, I did not view the 5 video with the notion of adding up the number 6 of strikes. I'd have to look at it again. I 7 don't know that. 8 Q. The taser had an effect each time it 9 was deployed that you could observe; correct? 10 A. I'd have to look at the video again 11 to answer the question. 12 Q. You have no memory? 13 A. I have no independent recollection 14 of that. 15 Q. When you say that it's important to 16 note that individuals are intoxicated, why is 17 it important to note, when you say that at the 18 bottom of -- 19 A. It's important to note that 20 dextromethorphan intoxication, in and of 21 itself, can cause violent behavior. Why is it 22 important to note that? It's important to note 23 that, because there are three possibilities in 24 this matter. One is that the gentleman was 25 agitated and became violent in the setting of</p>	<p style="text-align: right;">Page 100</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 asked, Question No. 3 is what was Mr. Smith's 3 strength potential. Again, that isn't in the 4 105 things that you list here, is it? 5 A. No. But with all due respect, if 6 someone routinely treats violent patients, I 7 believe there is clinical experience and 8 literature to support the contention that 9 individuals who are acutely psychotic from any 10 etiology can achieve levels of strength due to 11 agitation which would not have been predicated 12 simply by looking at their body habitus. I 13 don't think that's a far-flown concept. 14 I think any psychiatrist who has 15 ever worked in an emergency room setting with 16 chronic psychotic patients would have some 17 knowledge of that. 18 Q. So that's what you're relying on to 19 give that answer? 20 A. I have no doubt there is literature 21 about relatively benign looking patients who 22 are psychotic achieving rather substantial 23 feats of strength, and I can certainly obtain 24 those for you if you need them. 25 Q. I'm just wondering if you looked at</p>
<p style="text-align: right;">Page 99</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 unmedicated or undermedicated psychosis. 3 The second would be that the 4 gentleman became violent because of 5 dextromethorphan intoxication. And the third 6 possibility is that he became violent from 7 both. 8 If one were to posit that his 9 psychotic disorder were somehow under good 10 control, a supposition which I believe is 11 incorrect, one could still explain the violent 12 behavior based on the presence of the 13 dextromethorphan. 14 Q. The only violent behavior that you 15 noticed was in response to and after, 16 temporally, the police laid hands on him? 17 A. The only overt act of violence 18 occurred around that time, and I would have to 19 look at the video again to obtain whether it 20 preceded any police intervention or was 21 subsequent to any police intervention. 22 Q. You just don't remember? 23 A. I do not -- I have no independent 24 recollection of that. I'd have to look. 25 Q. Now, I looked at -- and then you're</p>	<p style="text-align: right;">Page 101</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 any before you looked at the report. 3 A. No. That would be something that is 4 part of my background and training and 5 experience. 6 Q. So what -- I mean, what 7 extraordinary strength did David Smith evidence 8 in what you saw? 9 A. From the pen cam it was an extended 10 struggle. 11 Q. How long? 12 A. I didn't time it. There may be 13 times stamps on the pen cam. I don't recall 14 what they are. Multiple minutes. 15 Q. Well, more than two? 16 A. I believe so. But I'd have to look. 17 Q. And he fell down when the taser -- 18 the first two applications of the taser; 19 correct? 20 A. I was aware that he fell down during 21 the course of the altercation. 22 Q. So the taser had that effect on him, 23 the neuromuscular disruption? 24 A. I don't know that. 25 Q. You don't know that?</p>

<p style="text-align: right;">Page 102</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 A. That would be a reasonable 3 supposition, but I don't know that, per se. 4 Q. Do you know any other reason he fell 5 down? 6 A. He could have tripped. 7 Q. Did you see him get tripped? 8 A. I did not examine the video with the 9 purpose of codifying and explaining each and 10 every physical act present on it. 11 Q. Well, you say his capacity for 12 extended periods of high physical exertion 13 related to violence would have been 14 substantial. 15 A. Yes, sir. 16 Q. And you <u>claim</u> to have the foundation 17 to say that; correct? 18 A. Based on my clinical experience and 19 training, yes. 20 Q. All right. And, you know, was this 21 struggle any longer than, for example, a round 22 in amateur boxing of a minute and a half or -- 23 A. Let me go back for a second. You 24 had asked me if I had referenced the pen camera 25 video in my report and, in fact, the next</p>	<p style="text-align: right;">Page 104</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 sentence, but you're correct, that's part of a 3 sentence. 4 Q. You don't hold the opinion to a 5 reasonable degree of medical certainty that 6 David Smith was suffering from excited 7 delirium, do you? 8 A. I don't have enough information to 9 render that diagnosis, that's correct. 10 Q. So then no would be the answer? 11 A. Certainly, the behavior could have 12 been indicative of that, but there is not 13 enough information to render that diagnosis, so 14 the answer would be no. 15 There are other explanations extant 16 at the time of the event that would also 17 explain the behavior, which we know are 18 factual, i.e. the psychotic disorder and the 19 dextromethorphan intoxication. 20 Q. Okay. When you describe this 21 prolonged struggle, going back to your 22 statement there, are you saying that an 23 ordinary human being does not have the capacity 24 to struggle for that period of time to a 25 reasonable degree of medical certainty?</p>
<p style="text-align: right;">Page 103</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 sentence references the pen camera video, just 3 to amend my prior answer. 4 Q. And then he jumped into an excited, 5 delirium-like state. When you say like, what 6 does that mean? Because I used to ask my kids 7 that. 8 A. We don't know if he was delirious, 9 but the types of behaviors he was evincing 10 coupled with the dextromethorphan intoxication 11 would indicate that delirium is in the 12 differential diagnosis for the behavior. 13 Q. Not according to Dr. Andrew Baker; 14 right? He said that there was no -- that 15 excited delirium played no part in David 16 Smith's case. There wasn't any. 17 A. I'm not here to comment on his 18 testimony. 19 Q. Did you read it? 20 A. Yes. 21 Q. You opine that Mr. Smith's prospects 22 for gainful employment or educational 23 achievement were negligible? 24 A. Excuse me one second. There is a 25 preceding sentence which explains that</p>	<p style="text-align: right;">Page 105</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 A. When you say ordinary, could I ask 3 you to -- I mean -- 4 Q. Well, me. How about that? I am 5 only 61, but I figure I could still fight for 6 three minutes if I had to, even two. 7 A. There could be many so-called normal 8 individuals that could engage in an extended 9 altercation of the type captured by the pen 10 cam. 11 Q. Do you know how long, for example, 12 the armed forces trains individuals to be able 13 to engage in hand-to-hand combat? 14 A. No. 15 Q. Excited delirium is not recognized 16 in the diagnostic and statistical manual for -- 17 A. Delirium is, but the term excited 18 delirium is not. 19 Q. Or by the American Medical 20 Association; correct? 21 A. What about the American Medical 22 Association? What was the question again? 23 Q. Excited delirium is not recognized 24 by the American Medical Association. Let's 25 leave it at that first.</p>

<p style="text-align: right;">Page 106</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 A. Not recognized, I'm not sure what 3 you're referencing. It's a very broad 4 statement. There may be literature the 5 American Medical Association's published which 6 could contain the term excited delirium. I 7 don't know that.</p> <p>8 Q. Well, it's not -- excited delirium 9 is not described in -- what's the -- IC --</p> <p>10 A. ICD-9 or ICD-10?</p> <p>11 Q. Yes.</p> <p>12 A. I don't know if you can code excited 13 delirium in ICD-10. But, certainly, it's well 14 described that delirium can have different 15 manifestations, a lethargic delirium, an 16 excited delirium, a delirium that waxes and 17 wanes between lethargic and excited. There can 18 be so-called lucid intervals. All of those are 19 possible.</p> <p>20 Q. Let's just be clear. You're not 21 opining that David Smith had excited delirium 22 or died from it; right?</p> <p>23 A. I'm not opining at all about what he 24 died from.</p> <p>25 Q. I assume whether he had it, you</p>	<p style="text-align: right;">Page 108</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 substantial degree of strength to the extent 3 that two police officers were having a hard 4 time subduing him. I wouldn't use the word 5 superhuman. What was the other term?</p> <p>6 Q. Or even an elevated level of human 7 strength.</p> <p>8 A. Elevated level. Elevated above a 9 normal baseline. Can I say that within a 10 reasonable degree of medical certainty? I 11 would say given the factors extant, unmedicated 12 psychosis and the dextromethorphan intoxication 13 coupled with what appears to me to be an 14 extended altercation with two trained police 15 officers, I believe I would state within a 16 reasonable degree of medical certainty that his 17 strength level was elevated above his normal 18 baseline as a result of those conditions.</p> <p>19 Q. And you claim to have observed that 20 visually in the pen camera video?</p> <p>21 A. Yes. The pen cam appears, to my 22 looking at it -- I'm not a police officer -- 23 but to be quite a fight.</p> <p>24 THE COURT REPORTER: Quite 25 what?</p>
<p style="text-align: right;">Page 107</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 cannot come to that judgment?</p> <p>3 A. I cannot. And there are other 4 extant conditions which could also explain the 5 behavior which are diagnosable.</p> <p>6 Q. What facts are you relying upon to 7 provide the opinions that his prospects for 8 gainful employment or educational achievement 9 were negligible?</p> <p>10 A. The universe of factors that we have 11 been discussing for the past few hours and per 12 the discovery material he had not held a job 13 since 2006 and, I believe, was unable to 14 navigate his single attempt at college, not a 15 full college load, but simply a course or two. 16 So I think that plus other factors plus the 17 fact that -- his overall clinical course, to my 18 reading of the record, was worsening with time, 19 would all inform that statement.</p> <p>20 Q. You're not opining to a reasonable 21 degree of medical certainty that David Smith 22 exhibited superhuman or even elevated levels of 23 strength, are you?</p> <p>24 A. Within a reasonable degree of 25 medical certainty, he certainly exhibited a</p>	<p style="text-align: right;">Page 109</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 THE WITNESS: Quite a fight.</p> <p>3 Q. Do you have any police use of force 4 training? Were you ever involved with that?</p> <p>5 A. No.</p> <p>6 Q. You have no idea if the police were 7 employing proper police force techniques?</p> <p>8 A. No, I do not.</p> <p>9 Q. Are you relying on any scientific 10 articles or studies to help you with the 11 opinion that his chance for gainful employment 12 or educational achievement were negligible?</p> <p>13 A. No. That's predicated on the record 14 and the factors that I described as contained 15 within the record.</p> <p>16 Q. Do you think you have a better idea 17 of whether people with schizophrenia or 18 schizoaffective disorder are able to be 19 gainfully employed or educated if you treat 20 them for it rather than if you look at it on a 21 paper record, since you treat between 50 and a 22 hundred --</p> <p>23 A. Right.</p> <p>24 Q. -- psychotic disorder patients?</p> <p>25 A. I think you can write it both ways.</p>

<p style="text-align: right;">Page 110</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 There may be clinicians who would be more 3 astute than the record. The record is really 4 meant to reflect what the clinician sees. And 5 so the record that I read, I think, is 6 reflective of the statements that I've made. 7 But I think to answer your question, 8 I think you could write that story both ways. 9 They might be better than the record, they 10 might not. They could be worse than the 11 record.</p> <p>12 MR. BENNETT: Let's go off the 13 record for a second.</p> <p>14 THE VIDEOGRAPHER: Going off 15 the record at 11:41 a.m.</p> <p>16 (Off the record.)</p> <p>17 THE VIDEOGRAPHER: We're back 18 on the record at 11:46 a.m.</p> <p>19 Q. You don't have any idea of David 20 Smith's strength baseline, do you?</p> <p>21 A. No. I haven't seen him tested on a 22 strength dynamometer or something like that.</p> <p>23 Q. You don't have any scientific 24 measurements reflecting the force that Smith 25 was exerting during the struggle, do you?</p>	<p style="text-align: right;">Page 112</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 think I did. 3 Q. But did you have a chance when you 4 were looking through your stuff to see if 5 you've got Dr. Zimmerman or Maureen Glover's 6 deposition? 7 A. If it's not listed here, I don't 8 have it. 9 Q. Okay. Have you ever personally 10 treated a patient who suffered from psychosis 11 and substance abuse that was able to ultimately 12 gain employment and further their education? 13 A. Yes. It's usually predicated on 14 prolonged abstinence from alcohol or drug abuse 15 and compliance with treatment, but, yes, I've 16 seen those types of patients. 17 Q. And there are drugs that you now 18 have available that we talked about, the 19 clozapine and the long-acting inhibitors that 20 Dr. Schulz talked about that would help in that 21 process; correct? 22 A. Could help, yes. 23 Q. Correct. My word was wrong there. 24 They're designed to help? 25 A. Yes, sir.</p>
<p style="text-align: right;">Page 111</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 A. As in foot-pounds, no. 3 Q. By any measuring capability? 4 A. No. I mean, it looks like he was 5 putting up a pretty good fight, but I can't say 6 for more than that. 7 Q. Your observation that it appeared to 8 be quite a fight or a good fight is the same 9 observation any lay person could make, though, 10 isn't it? 11 A. Well, I've seen probably more than 12 my share of fights because of the work I've 13 done in prisons and in the emergency room. So 14 I think it would be somewhat different than the 15 average lay person, hanging out in a bad area. 16 Q. When you look at the record, in the 17 record did you see opinions from people that he 18 was employable, that he was educable? 19 A. I saw documents that stated that 20 appeared to lack life skills regarding 21 independent living and/or educational work 22 achievement. I believe I also saw -- did I see 23 records in time point regarding those issues, 24 where people expressed opinions as to his 25 employability or capacity to pursue school? I</p>	<p style="text-align: right;">Page 113</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 Q. Are there any studies that you're 3 relying on, specific studies, to provide this 4 opinion? 5 A. The employability and prospects of 6 further educational achievement? 7 Q. Yes. 8 A. No. That's predicated upon my 9 reading of the record. 10 Q. And your experience and education 11 and general -- 12 A. Yes, sir. 13 Q. Do you agree that David Smith 14 expressing desire to go to college and work are 15 motivational factors that would be part of -- 16 take any part in increasing the good outcome in 17 a schizoaffective disorder? 18 A. Good clinical outcome? 19 Q. Yes. 20 A. As in would his symptoms get better 21 because he wanted to go to college or work? 22 Q. If he actually had the desire to do 23 something like that. 24 A. Not necessarily. Sometimes patient 25 have to walk before they run. And if their</p>

<p style="text-align: right;">Page 114</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 goals are too inflated, they're not willing to 3 go through the steps necessary to get to that 4 point, that can be deleterious. 5 Having said that, it is possible 6 that his or a patient with schizoaffective 7 disorders' wish to have those achievements 8 could have a decided effect on his overall 9 prognosis. 10 Q. You're unaware of any of his 11 family's knowledge at any point in time of his 12 psychosis? 13 A. Actually, let me go back and amend 14 my answer. The gentleman had also had a brain 15 injury and had neuropsychological testing that 16 was not normal and appeared to show cognitive 17 deficits from brain injury. 18 Q. Where did he get this 19 neuropsychological testing? 20 A. Let me find that for you. 21 Q. Yes. Because I don't remember that 22 he had a full neuropsych workup. 23 A. Yes, he did. I can't see without my 24 glasses.</p>	<p style="text-align: right;">Page 116</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 Q. That's what it says in the English 3 language in the conclusion, right? 4 A. Point to me where you're referring 5 to. 6 Q. I'll just have to see it for a 7 minute. 8 A. Yeah, sure. 9 Q. "He has had some significant head 10 injuries, although there is no medical 11 documentation to substantiate any long-lasting 12 effect." 13 A. Right. Your question to me was they 14 didn't document any cognitive effects of the 15 traumatic brain injury. The report states, 16 quote, "Mr. Smith has cognitive difficulty with 17 attention to nonverbal material, vocabulary, 18 and visual and graphic skill. He shows 19 variability for mental control, nonverbal 20 reasoning, and planning. 21 "He shows relative strength for 22 verbal fluency. The etiology of the above 23 listed difficulties is likely multifactorial. 24 He has had some significant head injuries, 25 although there is no medical documentation to</p>
<p style="text-align: right;">Page 115</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 to go off? 3 MR. OSBORNE: Yes, let's go 4 off the record. 5 MR. BENNETT: Sure. 6 THE VIDEOGRAPHER: Going off 7 the record at 11:52 a.m. 8 (Off the record.) 9 THE VIDEOGRAPHER: We're back 10 on the record at 11:55 a.m. 11 A. I have found the document that you 12 asked me about. 13 BY MR. BENNETT: 14 Q. Who is the provider? 15 A. Carroll Neuropsych Services and 16 C-O-U-N-S-E. I'm assuming that's counseling, 17 but -- 18 Q. I don't know what that is. 19 A. That's got to be counseling, and it 20 was cut off. 21 Q. Okay. They didn't find any 22 neuropsychological evidence that would 23 corroborate the head injury; correct? 24 A. Hold on just one second. No. 25 That's not the way I read this report.</p>	<p style="text-align: right;">Page 117</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 substantiate any long-lasting effect." 3 The way that I read this is there 4 are, in fact, cognitive abnormalities. With 5 all due respect to the author, I don't think 6 it's possible to say they are or are not due to 7 the head injury. You have to consider that. 8 What I was speaking to in 9 referencing the document is the individual's 10 capacity to pursue gainful employment or 11 school. So whether he has a head 12 injury-related cognitive problem or not, he 13 clearly has cognitive problems. 14 Q. You didn't mention a head injury or 15 TBI in your report at all. 16 A. I didn't. But in being responsive 17 to the question, it struck me as relevant. 18 Q. Well, in fairness to you, 19 Mr. Osborne did ask about whether a TV fell and 20 hit him on the head, and one of his siblings, 21 one of his brothers or two of his brothers 22 mentioned that, and he did fall out of a second 23 story window. They remembered that. Or was it 24 off a roof? 25 MR. OSBORNE: It was off a</p>

<p style="text-align: right;">Page 118</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 balcony. 3 MR. STORM: Or, no, it was 4 out of a window. 5 MR. BENNETT: But he didn't 6 even go to a doctor, as I recall. 7 MR. OSBORNE: There was no 8 record of doctors, no. 9 MR. BENNETT: They said they 10 just woke him up. 11 A. That's a bad sign. I mean, wakening 12 up sounds like he had a loss of consciousness, 13 which is problematic. Okay. Enough. I'll 14 stop. 15 BY MR. BENNETT: 16 Q. In any event, you didn't read any of 17 the available body of evidence from the family 18 about his relationship with them; correct? 19 A. Their relationship with him? 20 Q. Yes. 21 A. That is correct, I have not seen any 22 of their deposition testimony. 23 Q. And it is not unusual at all for 24 people who are being treated for mental health 25 disorders not to divulge or disclose their</p>	<p style="text-align: right;">Page 120</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 rendering your opinions that -- well, tell me 3 what your opinions are with regard to his 4 emotional capacity to provide a stable, loving, 5 and supportive influence to other family 6 members. I guess that was the question. 7 A. Well, stable, given his clinical 8 situation through 2010, his life was anything 9 but stable. And I don't think -- I think the 10 instability would apply also to that factor as 11 pertains to interaction with family members. 12 The issue of a loving and supportive 13 dovetails with stable. By all means he may 14 have loved his family, but the idea that given 15 the chaotic nature of his life in 2010, that he 16 was going to be able to be a loving and 17 supportive influence to his family, I just 18 think that the way he was living and the 19 clinical situation was inimical, 20 I-N-I-M-I-C-A-L, to that. It is just a very 21 chaotic life. 22 He was in Minneapolis, then he left. 23 He was psychiatrically hospitalized, and then 24 he came back. He was in and out of homeless 25 shelters, short-term placements for homeless</p>
<p style="text-align: right;">Page 119</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 relationships with their family to mental 3 health providers; correct? 4 A. I don't think that's true. I think 5 there are certain mentally ill patients who 6 would be reticent to disclose personal 7 information, including that sort of 8 information. I didn't get that sense from 9 Mr. Smith's records, but that is possible. 10 And I don't think the majority of 11 psychiatrically ill patients or even the 12 majority of patients with a psychotic disorder 13 invariably are reticent or frequently are 14 reticent to divulge family information. 15 Q. Well, again, you didn't read the 16 depositions of Maureen Glover or Joshua 17 Zimmerman who say, at least in their 18 experience, David's not sharing was consistent 19 with a lot of other people not sharing their 20 family histories? 21 A. They're certainly free to say 22 whatever they wish. The record that I reviewed 23 showed he was quite forthcoming on a number of 24 issues, including those types of things. 25 Q. What evidence did you consider in</p>	<p style="text-align: right;">Page 121</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 individuals. It just doesn't strike me as a 3 situation consistent with a stable family life. 4 Q. Okay. Did you read any depositions 5 in which he was called charming? 6 A. I've seen records that describe him 7 as a charming person or a person capable of 8 that. 9 Q. Did you read the notation or were 10 you aware that many of his providers indicated 11 they liked him very much? 12 A. I think he was a likable but 13 difficult patient, but I didn't get the 14 sense -- I mean, there are certain patients who 15 are very difficult to interact with, and you 16 can't get information, or they're always angry. 17 And I didn't get any sense of that. 18 I got the sense that those who 19 treated him didn't have those types of problems 20 to contend with. So therefore, I guess by 21 default, he would have been a reasonably 22 likeable individual. 23 Q. And if a 38-year veteran of 24 behavioral services and social work says that 25 he was very motivated and rewarding to work</p>

<p style="text-align: right;">Page 122</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 with and appreciated getting support and 3 services, despite his mental illness, would 4 that tend to color your view? 5 A. Could you repeat the question back 6 to me. 7 (The Reporter read back part 8 of the question, as requested.) 9 A. Let me stop you there. I didn't see 10 motivation. You know, motivation also implies 11 activity, and I just didn't see that, the 12 compliance with treatment and things of that 13 nature. Could you read the rest of the 14 sentence, please. 15 (The Reporter read back the 16 rest of the question, as requested.) 17 A. I do agree that he appreciated the 18 support that he got, although at times he was 19 not accepting of it and would be removed from 20 certain places because of noncompliance with 21 the treatment rules. 22 So your question is those factors, 23 would they color my opinion that he was not 24 capable or had limited capacity to provide a 25 stable, loving, supportive influence to other</p>	<p style="text-align: right;">Page 124</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 information from the family or those with whom 3 he had the closest personal relationships like 4 his girl friend? 5 A. I did not see their deposition 6 testimony. I relied upon the records to reach 7 that opinion, the records that were in my 8 possession, the clinical records to reach that 9 opinion. 10 Q. You had read Dr. Schulz's report 11 before you rendered yours; correct? 12 A. Yes, sir. 13 Q. You did not discuss, in your report, 14 the long-acting drugs and the clozapine; 15 correct? 16 A. Correct. 17 Q. And you made no attempt to discern 18 or opine on his mother and siblings' 19 relationship with him, from their perspective? 20 A. Given that I haven't seen their 21 deposition testimony, I wouldn't have the basis 22 to do that. 23 Q. When you say he had a propensity for 24 extended periods of bizarre, violent behavior, 25 what are the propensity instances you're</p>
<p style="text-align: right;">Page 123</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 family members? No, it would not. 3 Q. Do you have an opinion, to a 4 reasonable degree of medical certainty, whether 5 David Smith was capable of having caring human 6 relationships? 7 A. I think he was capable of that, 8 particularly if he was sober and medicated. 9 Q. And he had a six-year relationship 10 described as positive with his girl friend; 11 right? 12 A. Correct. 13 Q. Did you ever see his drawings? 14 A. I don't think I've seen that. 15 Q. Did you see references describing 16 him as a, quote, pretty nice fellow? 17 A. I don't know if I saw that exactly, 18 but he seemed like a nice guy. There were 19 times that he could be a handful and difficult, 20 but I think, on balance, he was a likable 21 individual, particularly when not substance 22 abusing and/or in the throws of unmedicated 23 psychotic disorder. 24 Q. So your opinions expressed in the 25 answer to Question No. 5 did not include any</p>	<p style="text-align: right;">Page 125</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 thinking of? 3 A. What are the instances I'm thinking 4 of? 5 Q. Yes. What is the foundation for 6 that, and do you hold it to a reasonable degree 7 of medical certainty? 8 A. I'm just looking for the sentence. 9 Q. Second to last paragraph? 10 A. On Page? 11 Q. 5. 12 A. Thank you. So what I wrote was, 13 quote, "In summary, on September 9, 2010, 14 Mr. Smith presented as acutely psychotic and 15 violent, more likely than not due to an 16 unmedicated psychotic disorder coupled with 17 acute, severe dextromethorphan intoxication. 18 Both of these factors, particularly together, 19 are associated with a propensity for extended 20 periods of bizarre, violent behavior." 21 I think that's a statement of fact. 22 Patients with unmedicated psychotic disorders 23 can engage in extended periods of bizarre, 24 violent behavior. And patients who are acutely 25 intoxicated with high levels of</p>

<p style="text-align: right;">Page 126</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 dextromethorphan can have a propensity for 3 extended periods of bizarre, violent behavior. 4 And those two conditions together would be 5 synergistic, thus increasing the risk for that 6 type of outcome.</p> <p>7 Q. Are we off? 8 A. No. That's okay.</p> <p>9 Q. Are you looking for something? 10 A. I thought I was, but I think I have 11 it here.</p> <p>12 Q. Who picked what depositions you 13 would get? 14 A. I don't know. 15 Q. It wasn't you, though? 16 A. No. 17 Q. Did you read the one of William 18 Christopher Taylor? It says that you got it. 19 A. Yes. 20 Q. And he didn't describe any act of 21 violence on the part of Mr. Smith, did he? 22 A. Hold on just one second. I'd have 23 to look at his deposition. I don't recall. 24 Q. But none comes to your mind as you 25 sit here today?</p>	<p style="text-align: right;">Page 128</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 expert in the treatment of schizophrenia and 3 schizoaffective disorder? 4 A. Yes. I might not agree with 5 everything he had to say, but I would recognize 6 him as an expert.</p> <p>7 Q. Well, would it be fair to say he has 8 a great deal more experience with schizophrenia 9 and schizoaffective disorder than you?</p> <p>10 A. You know, it depends on what you 11 mean by experience. He's certainly done a lot 12 of research, and it appears he's done a fair 13 amount of clinical work. I'm not sure how much 14 of that he does currently.</p> <p>15 I've seen an awful lot of 16 psychiatric spectrum patients, particularly in 17 the criminal justice system. I don't have a 18 basis to say one way or the other. That's a 19 reasonable supposition, but I'm not sure I can 20 say more than that.</p> <p>21 Q. Have you ever been chair or chief of 22 the department of psychiatry in any university? 23 A. No. 24 Q. The National Institute of Mental 25 Health, is that a well recognized organization?</p>
<p style="text-align: right;">Page 127</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 A. I have no spontaneous recollection 3 of that. I'd have to look at the record. 4 Q. Were you aware of the fact that his 5 sister visited him in Minneapolis? 6 A. I was not aware of that. 7 Q. Were you aware that she spoke on the 8 phone with him on a regular basis, even 9 discussing his disease? 10 A. No. 11 Q. Were you aware that she would pray 12 with him about his disease and often fall 13 asleep with him on the phone? 14 A. No. 15 Q. Are you opining that the individuals 16 afflicted with the illnesses and problems that 17 Mr. Smith had are incapable of providing love 18 and support and other value to the family 19 members? 20 A. No. 21 Q. Have you been asked to provide any 22 additional opinions that we haven't discussed 23 today? 24 A. Not at this time, no. 25 Q. Would you recognize Dr. Schulz as an</p>	<p style="text-align: right;">Page 129</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 A. Yes. 3 Q. The University of Pittsburgh has a 4 schizophrenia program; correct? 5 A. It does. 6 Q. And before you came there, he was 7 chair of that department; correct? 8 A. I believe that's correct. 9 Q. And he's written six books on 10 schizophrenia. Have you written any? 11 A. I have not written any. 12 Q. Are you a member of the 13 International Congress of Schizophrenia 14 Research? 15 A. No. 16 MR. OSBORNE: Bob, I don't 17 know how long you're going to go on that line 18 of questioning, but I'm going to just put a 19 standing objection into relevance. 20 MR. BENNETT: Sure. Well -- 21 Q. Hearing voices is a prominent 22 feature of schizophrenia and schizoaffective 23 disorders? 24 A. Yes. 25 Q. Even if you're medicated, I think at</p>

<p style="text-align: right;">Page 130</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 least Dr. Zimmerman testified that the voices 3 are lower and muted? 4 A. That would be the hopeful outcome. 5 Q. That's what you want? 6 A. Frequently, the voices will 7 continue. In fact, that's the hallmark of a 8 chronic psychotic disorder is that you can turn 9 the volume down, but you can't shut it off. 10 Q. So that's not a surprising finding 11 in David's case? 12 A. No. 13 Q. Do you have patients that use 14 long-acting, injectable medications, the LAIs, 15 yes? 16 A. Yes. 17 Q. In what situation do you prescribe 18 those? 19 A. Generally, it's to try to enhance 20 compliance in patients who have limited insight 21 into their disorder and have a history of 22 noncompliance. 23 Q. So enhancing compliance would be the 24 same as enhancing adherence? 25 A. Yes.</p>	<p style="text-align: right;">Page 132</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 THE VIDEOGRAPHER: Going off 3 the record at 12:20 p.m. 4 (Off the record.) 5 (Deposition Exhibit Nos. 9 6 through 11 were marked for identification.) 7 THE VIDEOGRAPHER: We're back 8 on record at 12:45 p.m. 9 BY MR. BENNETT: 10 Q. So we talked about these three 11 articles before, and we've had them marked for 12 purposes of making the record complete. 13 Exhibit 9 is the dextromethorphan fact sheet 14 from National Highway Transportation Safety -- 15 A. Administration. 16 Q. -- Administration? 17 A. Yes, sir. 18 Q. Exhibit 10 is the Massive 19 Dextromethorphan Injection and Abuse from the 20 American Journal of Emergency Medicine, 21 Volume 13, Issue 2, March 1995. 22 A. Yes, sir. 23 Q. And Exhibit 11 is a brief report 24 entitled Severe Manifestation of Coricidin 25 Intoxication. That's Exhibit 11. Correct?</p>
<p style="text-align: right;">Page 131</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 Q. All right. And it's true that 3 anticonvulsant medications are used to enhance 4 treatment of schizophrenia; correct? 5 A. Primarily as mood stabilizers, more 6 so in schizoaffective disorders than 7 schizophrenia, but yes. 8 Q. Schizophrenia and schizoaffective 9 patients often compartmentalize their lives? 10 A. I'm going to have to ask you what 11 you mean. 12 Q. Well, they don't wish to share their 13 suffering from a stigmatizing mental disorder 14 with certain family or friends, that sort of 15 thing? 16 A. That can happen, yes. Not 17 invariably true, but it can happen. 18 Q. Did you read any of the studies 19 cited by Dr. Schulz, the Robinson study, the 20 Harding study? 21 A. Some of those are known to me. I 22 did not pull them and reread them. Some of the 23 studies he cited, I have not read. 24 MR. BENNETT: Let's go off the 25 record for a few minutes.</p>	<p style="text-align: right;">Page 133</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 A. Yes. 3 Q. Have you ever read any of 4 Dr Schulz's books? 5 A. I know I've read articles of him. I 6 don't think I ever read any of his books in its 7 entirety. 8 Q. The people that you treat with 9 schizophrenia or schizoaffective disorder, how 10 many of them are employed? 11 A. That's a good question. In some 12 form of gainful employment, including part-time 13 or funded or shelter employment? 14 Q. Sure. 15 A. I would say about a third. 16 Q. Have you done any -- is that 17 basically anecdotal on your part? 18 A. Yes. Trying to think back on the 19 folks I have and what they do and -- 20 Q. Do you have any criticism of 21 Dr. Schulz's expert report that you would want 22 to tell me about that I haven't addressed in 23 your report? 24 A. Let me call them observations. The 25 second report contains an anecdote regarding a</p>

<p style="text-align: right;">Page 134</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 patient who received an antipsychotic 3 medication and had a substantial reversal of 4 their clinical situation, an improvement. And 5 it appears to be offered -- well, I am not sure 6 why it's offered, because -- you know what, I 7 don't have any criticisms. That's my answer.</p> <p>8 Q. Okay. Any other experts that you 9 have any knowledge of or opinions related to 10 that you haven't expressed? I mean, I notice 11 you got other reports.</p> <p>12 A. Yes.</p> <p>13 Q. Dr. Glenn Hardin's, the 14 toxicologist, and Dr. Baden's report. I don't 15 know if you got Dr. Jack Ryan's report. I 16 think you got that, too.</p> <p>17 A. There may be points in each report 18 that I disagree with, but I'm not prepared to 19 sit and render -- to tell you that chapter and 20 verse.</p> <p>21 Q. And you don't have any opinion, as 22 you sit here today? That wasn't part of your 23 task, I guess?</p> <p>24 A. No, that is correct.</p> <p>25 Q. Have you received any additional</p>	<p style="text-align: right;">Page 136</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 (Whereupon, the above-entitled 3 matter was concluded at 12:51 p.m.) 4 ----- 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25</p>
<p style="text-align: right;">Page 135</p> <p>1 Dr. Bernstein - by Mr. Bennett 2 tasks other than as expressed in your original 3 report?</p> <p>4 A. No, sir.</p> <p>5 Q. Did you have to do a budget for this 6 case?</p> <p>7 A. No.</p> <p>8 Q. Do you ever do a budget?</p> <p>9 A. Sometimes when I'm asked to, yes.</p> <p>10 Q. But you weren't asked in this case; 11 correct?</p> <p>12 A. No.</p> <p>13 MR. BENNETT: That's all of 14 the questions I have.</p> <p>15 MR. OSBORNE: I don't have 16 anything, Bob. And Dr. Bernstein has already 17 said he wants to read and sign, so that's what 18 we'll do.</p> <p>19 MR. BENNETT: Thank you, 20 Doctor.</p> <p>21 THE WITNESS: Thank you, sir.</p> <p>22 THE VIDEOGRAPHER: Being that 23 there are no further questions, this deposition 24 is now concluded. The time is 12:51 p.m. 25 (Signature not waived.)</p>	<p style="text-align: right;">Page 137</p> <p>1 2 COMMONWEALTH OF PENNSYLVANIA) ERRATA 3 COUNTY OF ALLEGHENY) SHEET 4 Larry E. Smith vs. 5 Timothy Gorman and Timothy Callahan 6 7 I, LAWSON F. BERNSTEIN, JR., M.D., have 8 read the foregoing pages of my deposition given 9 on February 5, 2013, and wish to make the 10 following, if any, amendments, additions, 11 deletions or corrections: 12 Pg. No. Line No. Change and reason for change: 13 14 15 16 17 18 19 20 In all other respects the transcript is true 21 and correct. 22 23 LAWSON F. BERNSTEIN, JR., 24 M.D. 25 Subscribed and sworn to before me this day of _____, 2013. 26 27 Notary Public (RW)</p>

EXHIBIT 20

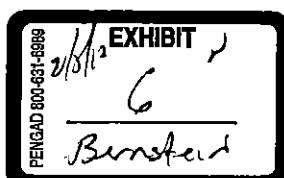
An
ICES/
PHO
Report

OPENING EYES, OPENING MINDS: The Ontario Burden of Mental Illness and Addictions Report

Summary



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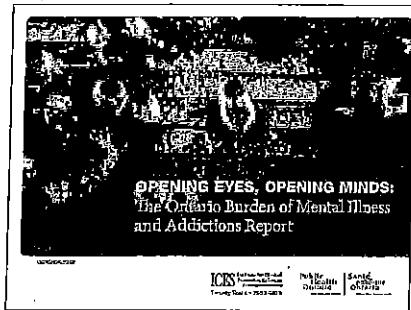
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Institute for Clinical Evaluative Sciences
Public Health Ontario

OPENING EYES, OPENING MINDS: THE ONTARIO BURDEN OF MENTAL ILLNESS AND ADDICTIONS REPORT

*You are invited to view the full report which is available
for download at www.ices.on.ca or at www.oahpp.ca.*



The opinions, results and conclusions reported in this paper are those of the authors and are independent from the funding sources. No endorsement by the Institute for Clinical Evaluative Sciences (ICES), Public Health Ontario (PHO) or the Ontario Ministry of Health and Long-Term Care (MOHLTC) is intended or should be inferred.

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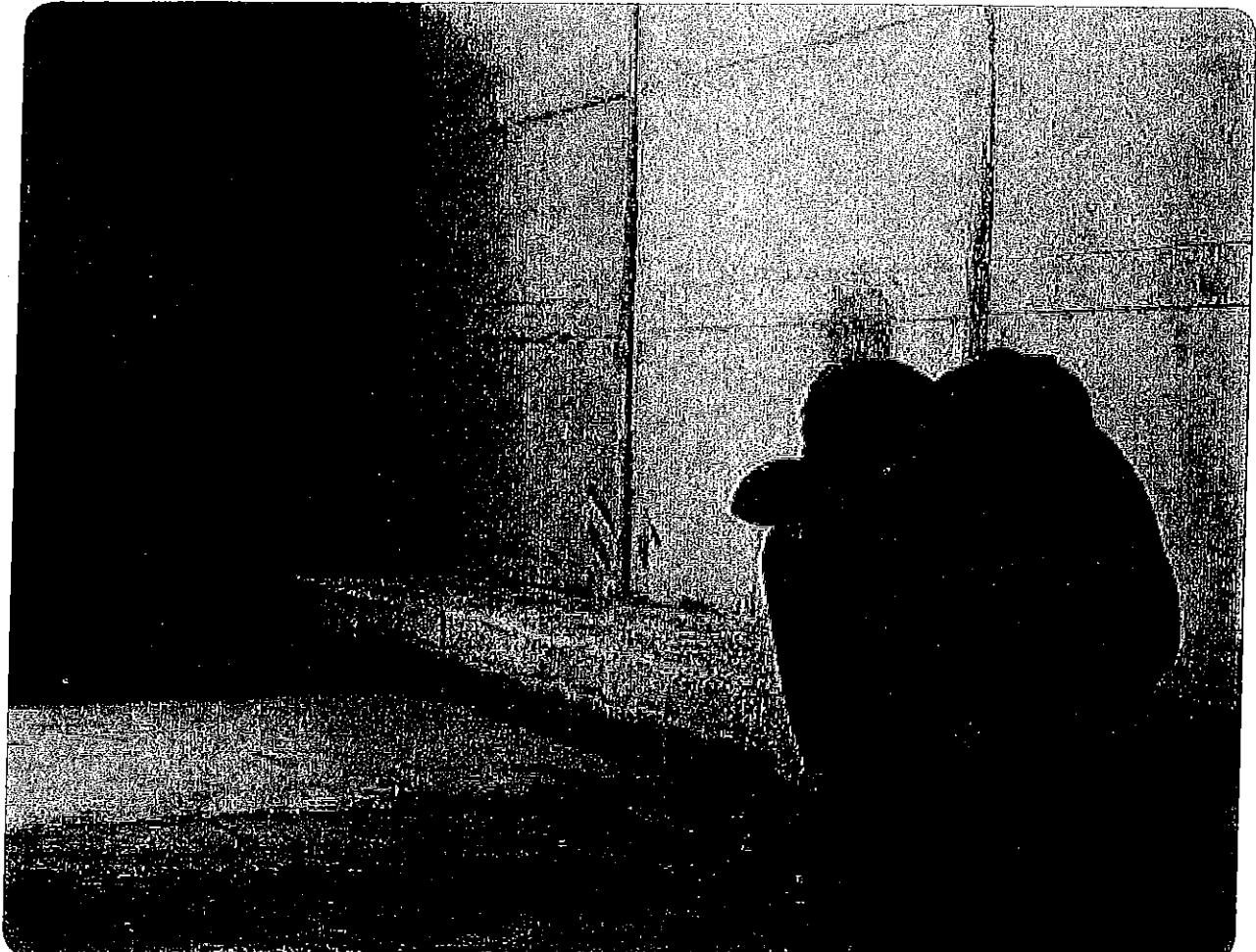
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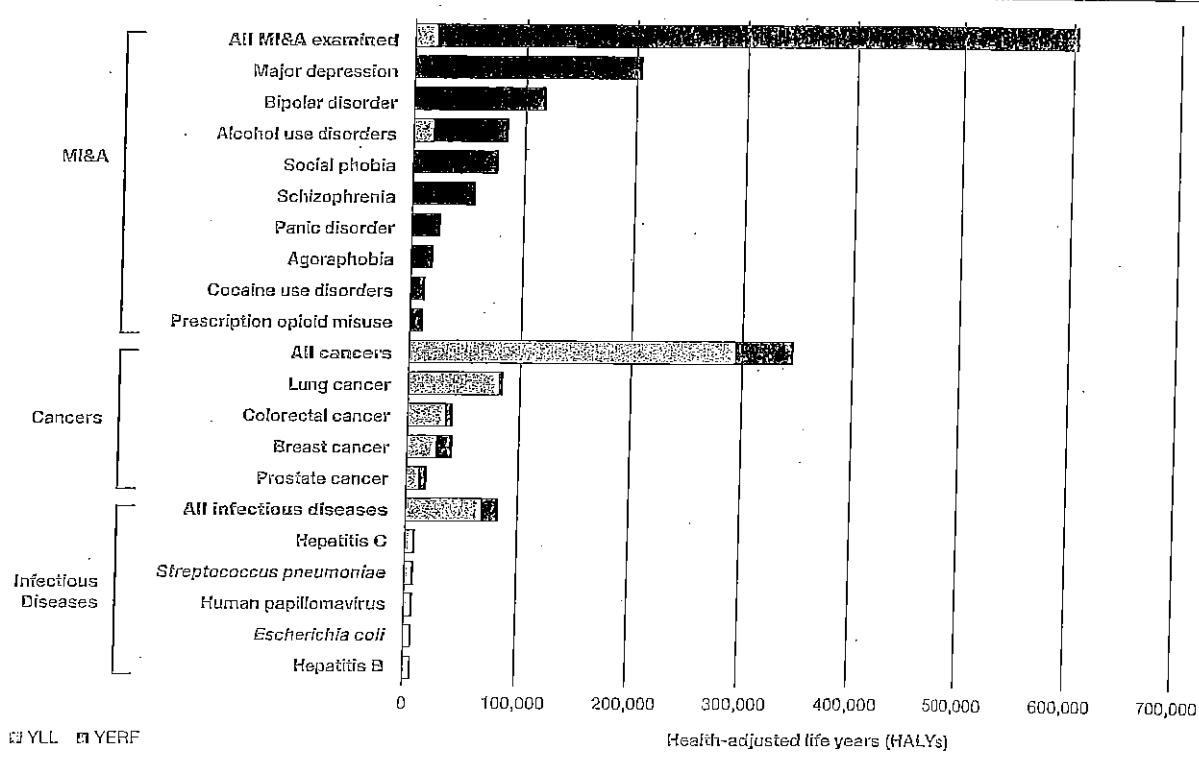
Findings

Most Ontarians are affected, either directly or indirectly, by mental illness and addiction issues. According to the Mental Health Commission of Canada, one in five Canadians is affected by a mental illness or addiction issue every year. Onset often occurs at a young age and can persist throughout life, with a significant impact on social connections, educational goals and workforce participation. The impact of mental illness and addiction on life expectancy, quality of life and health care utilization is significant—in many cases, more so than with other medical conditions—yet is often under-recognized.

The World Health Organization (WHO) defines health as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity. Mental health is a critical component of overall health. Measuring the burden of mental illness and addiction is an important step in ensuring that the needs of people who suffer from these conditions are understood and can be addressed. This study quantifies the burden and allows for comparison with other diseases and conditions.

The methods used in this study are conservative; they are based on a group of selected conditions and addictions that are highly prevalent and readily measured. Therefore, the findings do not reflect the total burden of mental illness and addiction in Ontario.

Burden of mental illness and addictions (MI&A) compared to cancers and infectious diseases in Ontario, by years of life lost due to premature mortality (YLL) and year-equivalents of reduced functioning (YERF)



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2 | The Impact of Mental Illness and Addictions

- The burden of mental illness and addictions in Ontario is more than 1.5 times that of all cancers and more than seven times that of all infectious diseases.
- The nine conditions identified in this report contributed to the loss of over 600,000 health-adjusted life years (HALYs), a combination of years lived with less than full function and years lost to early death in Ontario.
- Five conditions have the highest impact on the life and health of Ontarians: depression, bipolar disorder, alcohol use disorders, social phobia and schizophrenia.
- Depression is the most burdensome condition with twice the impact of bipolar disorder, the next highest condition. The burden of depression alone is more than the combined burden of lung, colorectal, breast and prostate cancers.
- In terms of deaths, alcohol use disorders contributed to 88% of the total number of deaths attributed to these conditions and 91% of the years of life lost to dying early.

Conclusions and Recommendations

Ontarians experience a high burden of illness related to mental illness and addictions. Individuals may be encumbered by these illnesses at a young age, experiencing the disruption of important life transitions, and challenged by their ongoing burden over a long period of time.

The findings of this study underscore the need for effective collaboration between health care providers, practitioners, policy-makers and researchers to identify effective mental health promotion and mental illness and addiction prevention interventions and improve access to treatment for those suffering from mental illness and addiction. Early detection and timely intervention are critical in reducing the lifelong burden of these conditions.

While effective treatments exist for mental illness and addiction, only a small proportion of affected individuals receive them. Given the significant burden, there is a need to consider population-based prevention, promotion and treatment strategies aimed at reducing the burden of mental illness and addiction in Ontario.

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ABOUT OPENING EYES, OPENING MINDS: THE ONTARIO BURDEN OF MENTAL ILLNESS AND ADDICTIONS REPORT

The Ontario Burden of Mental Illness and Addictions Report is the most thorough evaluation of the impact of mental illness and addictions undertaken to date in Ontario. A joint project of the Institute for Clinical Evaluative Sciences (ICES) and Public Health Ontario (PHO), the study sought to estimate the relative impact of a wide range of mental illnesses and addictions.

The objectives of this study were to:

- 1) Determine the burden of disease related to mental illness and addictions in Ontario;
- 2) Inform priority setting, planning and decision-making;
- 3) Establish a baseline for future evaluation of interventions that have an impact on the burden of mental illness and addictions;
- 4) Engage those working in public health in Ontario in a discussion on how to promote positive mental health and prevent mental illness and substance misuse and their associated health and social harms; and
- 5) Foster a dialogue between those working in mental health and public health on the mutual goal of promoting health and wellness for individuals with mental illness and addictions.

Methodology

The study used health-adjusted life years (HALYs), a composite health gap measure that incorporates both premature death (mortality) and reduced functioning or suboptimal states of health (morbidity) associated with disease or injury. HALYs quantify the amount of "healthy" life lost by estimating the difference between the health experienced within a defined population and some specified norm or goal. HALYs incorporate aspects of quality-adjusted life years (QALYs) and disability-adjusted life years (DALYs). HALYs are calculated by combining years of life lost due to premature death (YLLs) and year-equivalents of reduced functioning from living with the disease (YERFs).

Disease burden was estimated for nine mental illnesses and addictions for which reliable and valid Ontario data were available. Data on the nine conditions were acquired from a variety of different sources, including population health surveys and health administrative data. Deaths were estimated from vital statistics data.



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4 | ABOUT ICES

The Institute for Clinical Evaluative Sciences (ICES) is an independent, non-profit organization that produces knowledge to enhance the effectiveness of health care for Ontarians. Internationally recognized for its innovative use of population-based health information, ICES evidence supports health policy development and guides changes to the organization and delivery of health care services.

Key to our work is our ability to link population based health information, at the patient level, in a way that ensures the privacy and confidentiality of personal health information. Linked databases reflecting 13 million of 33 million Canadians allow us to follow patient populations through diagnosis and treatment and to evaluate outcomes. ICES brings together the best and the brightest talent across Ontario. Many of our scientists are not only internationally recognized leaders in their fields but are also practicing clinicians who understand the grassroots of health care delivery, making the knowledge produced at ICES clinically focused and useful in changing practice. Other team members have statistical training, epidemiological backgrounds, project management or communications expertise. The variety of skill sets and educational backgrounds ensures a multi-disciplinary approach to issues and creates a real-world mosaic of perspectives that is vital to shaping Ontario's future health care system.

ICES receives core funding from the Ontario Ministry of Health and Long-Term Care. In addition, our faculty and staff compete for peer-reviewed grants

from federal funding agencies, such as the Canadian Institutes of Health Research, and receive project-specific funds from provincial and national organizations. These combined sources enable ICES to have a large number of projects underway, covering a broad range of topics. The knowledge that arises from these efforts is always produced independent of our funding bodies, which is critical to our success as Ontario's objective, credible source of evidence guiding health care.

ABOUT PHO

Public Health Ontario (PHO) is a Crown corporation dedicated to protecting and promoting the health of all Ontarians and reducing inequities in health. As a hub organization, PHO links public health practitioners, frontline health workers and researchers to the best scientific intelligence and knowledge from around the world.

PHO provides expert scientific and technical support relating to communicable and infectious diseases; health promotion, chronic disease and injury prevention; environmental and occupational health; emergency preparedness; and public health laboratory services to support health providers, the public health system and partner ministries in making informed decisions to improve the health and security of Ontarians. PHO's work also includes surveillance and epidemiology, research, professional development and knowledge services.